Reviewer's report

Title: Guided online treatment in routine mental health care: an observational study on uptake, drop-out and effects

Version: 3 Date: 3 July 2012

Reviewer: Tine Nordgreen

Reviewer's report:

Thank you for the opportunity to review the manuscript 'Guided online treatment in routine mental health care: an observational study on uptake, drop-out and effects', by Robin MF Kenter, Lisanne Warmerdam, Christine AC Brouwer-Dudokdewit, Pim Cuijpers, and Annemieke van Straten.

The manuscript describes an observational study on uptake, drop-out and effects of an online treatment. The manuscript covers an important topic as it presents data regarding uptake and effect of a guided online problem solving treatment (PST) in routine health care. Numerous studies have already documented the effects of various guided online treatments. However, uptake, use, and drop-out needs to be addressed when these interventions are implemented into routine care. Overall, the focus of the manuscript is timely and relevant to the field of guided online treatments.

The questions posed by the authors are well presented in the Background section. However, it is not clear why the authors use both feasible (Background, paragraph 5) uptake (Title), and acceptable (Abstract) when they refer to patients using the interventions. Uptake may refer to therapists, patients, and health services’ “acceptability, accessibility and adverse consequences associated with (the intervention)” (Waller & Gilbody, 2009; Psychological Medicine, 39, 705–712). It may be helpful for the reader to get these terms clarified and used consistently throughout the manuscript. Available literature on this topic include also chapter 21 in “Oxfords Guide to Low Intensity CBT interventions” (Cavanagh, K.; Eds. Bennet-Levy and colleagues).

The PST intervention is well described in the manuscript. The main findings show that about half of the patients in the routine care started the PST intervention while waiting for a face-to-face treatment. Reasons for not starting the online PST treatment are reported in the Discussion section, Main results, line 4. It is not clear if all patients were assessed on these factors, or if these were anecdotal reports from a few participants. To make data available from all patients regarding fear of security on the internet, wanting to talk to a person instead, or not enough computer skills will enable examination of these factors as predictors of uptake of PST.

Large effects of time are reported, and also a group x time interaction at 5 weeks, in favor of the PST-group on depression, anxiety, and QoL measures, but not the Burnout measure. At 12 weeks, anxiety is reported to be different between the
two groups, in favor of PST group. No other measure differs across the two groups.

The authors included recovery as an outcome measure, which is a strength of the study. To add reliable change will complement the recovery / clinical change data.

The methods are appropriate and well described in this observational study, with relevant imputation procedure for missing data. In the Method section, Recovery (Table 4) it is unclear how anxiety and depression is merged into one category. The authors should review the standard range for labeling Cohen’s d as small, medium, and large.

Data was collected in routine care, and can therefor indicate uptake and effect of online treatment outside an university setting. This contributes to the knowledgebase of the field. However, data from routine care is associated with less extensive assessment compared to assessment in randomized controlled trials. In present study it is not reported data on patients’ motivation, patients’ readiness to change, or patients’ perceived credibility of the PST intervention. These factors may be associated with the uptake and effect of the PST-intervention, but is not reported in the manuscript. This is a major limitation of the study.

The manuscript adheres to the relevant standards for reporting and data deposition.

The discussion and conclusions are coherent with the presented data. However, the following limitations may be more thoroughly discussed in the Discussion section:

1) How was the uptake of the PST intervention affected by the fact that the face-to-face intervention was prescheduled?

2) May improvement in the PST group be confounded by patients’ motivation, patients’ readiness to change, or patients’ perceived credibility of the PST intervention? And not the intervention itself?

3) HADS had a low alpha. This indicates a low reliability of the instrument in this sample, and it would be interesting if the authors discussed how this may have affected the results.

4) Participants in the PST group were more likely to be younger, female, with lower education. This may be important indicators of uptake of PST, however, due to a small sample size, this may also be random findings. Implications of the identified predictors, including methodological limitations related to this finding, should be addressed.

The authors clearly acknowledge work upon which they are building related to the self-help literature. However, as mentioned above, the term uptake and literature relevant to this term may be elaborated in the introduction and discussion.

Drop-out is in the title suggested as one major theme in the manuscript, but not in the Introduction or Discussion sections.
The following is stated in the Abstract, conclusion section: “The results of this study suggest that guided online treatment for symptoms of depression and anxiety is acceptable for patients, increases speed of recovery and can therefore be offered as a first step of treatment in mental healthcare.” It should be considered how “acceptable for patients” relates to the term uptake and feasibility, and how this is related to data presented in the manuscript.

To present the definition of self-help brings clarity to the manuscript (Introduction, first paragraph). In the same paragraph the authors should reconsider their statement that self-help is opposed to a therapeutic relationship. As suggested by Richardson & Richards (2006) effects from self-help materials may partly be stimulated by the therapeutic relationship facilitated through self-help materials.

Taken together I have following suggested revisions:

Major compulsory revisions:
1) To include reliable change, as this will complement the recovery / clinical change data
2) To make data available from all patients regarding fear of security on the internet, wanting to talk to a person instead, or not enough computer skills as this will enable examination of these factors as predictors of uptake of PST.
3) In present study it is not reported data on patients’ motivation, patients’ readiness to change, or patients’ perceived credibility of the PST intervention. These factors may be associated with the uptake and effect of the PST-intervention, but is not reported in the manuscript. This is a major limitation of the study.

Minor Essential Revisions
1) It is not clear why the authors use the terms feasible (Background, paragraph 5), uptake (Title), and acceptable (Abstract) when they refer to patients using the interventions. It will be helpful for the reader to get these terms clarified and used consistently throughout the manuscript.
2) In the Method section, Recovery (Table 4) it is unclear how anxiety and depression is merged into one category.
3) In the Discussion section the following limitations may be more thoroughly discussed:
   a) How was the uptake of the PST intervention affected by the fact that the face-to-face intervention was pre-scheduled?
   b) May improvement in the PST group be confounded by patients’ motivation, patients’ readiness to change, or patients’ perceived credibility of the PST intervention? And not the intervention itself?
   c) HADS had a low alpha. This indicates a low reliability of the instrument in this sample, and it would be interesting if the authors discuss how this may affected the results.
   d) Participants in the PST group were more likely to be younger, female, with lower education. This may be important indicators of uptake of PST, however,
due to a small sample size, this may also be random findings. Implications of the identified predictors, including methodological limitations related to this finding, should be addressed.

Discretionary Revisions:

1) In the Method section, Recovery (Table 4) it is unclear how anxiety and depression is merged into one category. Please clarify.

2) The authors should review the standard range for labeling Cohen’s d as small, medium, and large.

3) Drop-out is in the title suggested as one major theme in the manuscript, but not in the Introduction or Discussion sections.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being published

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I have no reason to believe duplication or plagiarism has occurred. Neither do I believe that research has been falsified or manipulated, or identified any issues with the authorship or contributions towards the manuscript. Declaration of competing interests: I declare that I have no competing interests.