Reviewer's report

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

Version: 1 Date: 7 June 2007

Reviewer: Gregory Aarons

Reviewer's report:

General
This is an interesting article that grapples with implementation of cognitive-behavioral therapy for depression in adolescents in a usual care community-based outpatient agency and a school-based mental health agency. The study uses primarily qualitative methods. There are a number of strengths to the study including the real-world context, involvement of the researchers in formative as well as evaluative phases, and the use of a theory driven conceptual model. There are also some concerns that should be remedied, including lack of detail in reporting demographics and results (leading to uncertainty about the agencies and context), the veracity of the fidelity measures, and potential mis-labeling of the role of some participants (i.e., “champions”). These and other issues are addressed in more detail below.

Major Compulsory Revisions (that the author must respond to before a decision on publication can be reached)
The review of Roger’s 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.

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. Also please provide a better estimate of the number of clients served at each site. The overall estimate of 1000-2000 for both clinics is not very precise. This estimate may suggest extremely high variability in client flow for the organizations and work load of providers, or a lack of precision. A much tighter estimate should be possible and should be broken out by each site. It would also be helpful to know the average caseload per provider.

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?

Please specify the actual n and proportion of the sample that was female.

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? These fidelity measures appear weak also because the actual number of therapy audiotapes is not specified. It is only noted that sessions were audiotaped “if the patient allowed the therapist to do so.” How many patients consented to this? 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.

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 clarified or addressed in some way. Can the qualitative data address this?

Staff turnover is mentioned as an inhibiting factor but turnover rates are not given or discussed. Was there staff turnover for any of the participant service providers at any point in the study? Again in the discussion 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.

It really does not sound like the “champions” for the CBT intervention did much in the way of real leadership or moving the process forward. It appears that their role was primarily administrative in nature. These
people should be more accurately described in the manuscript.

It could be argued based on the results that this study demonstrates that CBT can barely be implemented in usual care publicly funded mental health settings and that the implementation approach 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. While the paper is framed in terms of an adaptation of Rogers’ stages, it appears that 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.

In the limitations section - the reader still knows almost nothing about the two clinics involved in this study so generalizability is not just limited, it is virtually non-existent. In order to assess generalizability, more information about the agencies would be required.

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 EBP?

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Minor Essential Revisions (such as missing labels on figures, or the wrong use of a term, which the author can be trusted to correct)
In the first paragraph, please provide percent along with number for recruitment and participants.

Table 2 is discussed as potentially providing a way to identify barriers and facilitator to CBT implementation, however, very little data is presented 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?

Future work should involve use of the formative evaluation to troubleshoot poor adoption and implementation such as that described in this study. In this study the formative evaluation appears not to have impacted the implementation to a great extent. It might be helpful to address this issue in the discussion.

There are some remedies for the “intrusion” of researchers? Research-practice partnerships, community-based participatory research, and participatory action research are all ways to reduce alienation that may result from the different cultures of research and practice. This is especially so if it is agreed that the common goal is to help children and families.

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Discretionary Revisions (which the author can choose to ignore)
n/a

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article of importance in its field

Quality of written English: Acceptable

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