Reviewer's report

Title: Delivering stepped care: an analysis of implementation in routine practice

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Reviewer: Annemieke van Straten

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Providing services along Stepped care principles is rapidly gaining popularity worldwide. Even though, as the authors argue, evidence for service delivery (how should it be offered?) is scarce or absent. This paper demonstrates very well what happens when implementing stepped care in the absence of such guidelines. It is one of the first papers demonstrating large practice variations in stepped care.

The main weakness of this paper is the lack of outcome data. Even though this is already acknowledged by the authors in their discussion section they might elaborate a bit more on this crucial point. E.g. I would like to know: is this data not collected at all in the services? or were these data just not available for research purposes? In case it is not collected at all it could be argued that none of these services actually implemented stepped care?

Another point which should be discussed more clearly is the way the stepped care was initially designed by the different services. In their methods section the authors state that they were involved in these designs. I therefore wonder what their role was (and to what extent they were responsible for the ‘failure of guidelines to be implemented in a manner consistent with the authors’ intentions.’ Page 20)? E.g. why did the different services came up with different models? Did the authors aim to create similar designs across services? Maybe some of the services were more ‘stepped care’ minded from the start than others? What did the services do to implement the design they had chosen? Was the staff trained and / or ….? Were the authors involved in this? Were there important differences between the services in the time, energy and money spent on actual implementation?

Table 2 shows us that there are 3 major steps within the stepped care design: guided self-help, short term face-to-face interventions, and more complex / specialized face-to-face interventions (next to assessment and crisis interventions). However, part of the paper is about ‘low’ and ‘high’ intensity treatments. I wonder if the authors regard the short face-to-face interventions as ‘low’ or ‘high’ intensity? This should be defined somewhere.

In my opinion Figure 3 and Figure 4 are not the most interesting. They do make your realize that the patient flow is diverse but nothing else. I think it would be more interesting to put more essential data in a bar chart. Like: the percentage of patients starting with a low intensity treatment, or percentage of patients stepping
up.

Minor points

The title should reflect that this paper is on delivery of mental health care (and not health care in general)

For non-UK readers the authors need to explain the difference between ‘specialized mental health trust’ and ‘primary mental health teams’ (page 12). Also: it is not clear whether the studied services were the only services available for GPs to refer to? Or are there other services and is only a selection of patients referred to the studied services?

The authors should explain more clearly what is meant by ‘para-professional mental health (or graduate) workers’ (page 12 and 13).

The authors argue that ‘large’ amount of data were missing. I would like to have some estimate of this proportion.

The patient flow shows us that about 75% of the referred patients are assessed. I guess that this means that the other patients are referred but don’t show up for their appointment in the service? Or are they screened by the service and ‘sent back’ to their GP? Or …??

The authors show on page 15 that unscheduled discontinuation rates are 43% for low-intensity treatments and 10% for high intensity treatments (might this also be due to selective missing data?) but on page 19 they show that only a third of the high-intensity treatments were completed. This is a bit confusing. And this is an important point since it is often thought that drop-out rates for low intensity treatments are much higher than for high intensity treatments. I wonder if this is demonstrated in this study or not?

Table 1: the abbreviation IMD should be explained.

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.

Declaration of competing interests:

I declare that I have no competing interests