Reviewer's report

Title: 'Getting a grip on depression': implementing a stepped care approach in primary care. Results of a qualitative study.

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Reviewer: Margaret Maxwell

Reviewer's report:

Major compulsory revisions

I feel there are some major confusions in the presentation of this piece of work. It is not clear whether the qualitative study relates to the implementation of the stepped care model or the QIC - it is difficult to disentangle the two, and I appreciate this, but the authors at times see the stepped care model as the driver for change and also the QIC. Then at the same time they are trying to identify what it is about the process of implementation within the stepped care model that drives change. It is hard to see what they constitute as the 'intervention' and what constitutes drivers of change in up-take of the intervention.

The abstract for example: what they offer as 'results' in the first half of that section is just the underlying principles of stepped care fed back to us. It would be better to describe how these principles were tailored to local circumstances to make them acceptable/implementable.

The use of NPT requires more consideration - the initial assumption of NPT that 'routing embedding of a complex interaction is the product of action' doesn't seem too helpful an introduction to this theory to me. Of course people would need to act to implement something! This explanation of NPT is too brief to understand what it is and how to apply it.

Gunn's use of the four mechanisms is more clearly explained but how does the NPT theory work - do all mechanisms need to be in place for success or can there be partial achievement and non achievement on some? Did this theory guide the analysis or offer a helpful way to interpret findings?

The descriptions of cognitive participation (reaching and agreement on interventions and becoming familiar with others skills p12 ) and collective action (team meetings to discuss roles and tasks) seem too similar. Some aspects of cognitive participation could also be described within 'coherence' which is about shared understanding. Engenders a feeling that the data may be being shoehorned into the theory.

It is also important to distinguish whether NPT mechanisms are providing insight into stepped care or the QI programme.

Results:
It is important to identify the participant type and not the team in presenting data.
The importance of the extracts lies in the different viewpoints of different professional groups. The different categories of depression may have been presented to primary care by others (secondary care psychiatrists?) and perhaps this lies at the heart of disagreements. It is not clear who needs to adjust their viewpoint or develop their capabilities to identify different depression levels - do psychiatrists need to learn more about different definitions within primary care and accommodate these?

There are many instances when the mechanisms for implementation are not achieved or are problematic - and yet we are given no summary of whether all projects were successful in implementing stepped care or to what extent. And could it be successful for individual practitioners, and not successful for others in the same location.

The final paragraph on page 12 is vague - when we are told that some clinicians (which type?) believe 'primary care physicians should be dealing with every single patient', what does this mean? That they should merely coordinate the care of all patients or actively manage them and deliver interventions (CBT or self help) too?

The comparison of stepped care to other 'one dimensional treatment concepts like in the care of diabetes.... for which evidence-based treatment standards can be developed and applied' is also confusing given that stepped care is about being multi-dimensional. And also implies that some clinicians hold that evidence based treatment standards cannot be developed and applied for depression. So who holds these views? I understand that the authors are trying to present the broad range of opinions and that not all were successful in getting full adoption of stepped care but with strong statements such as these we need a fuller description and discussion of what is implied.

The authors identify organisational, structural and cultural barriers to implementation - where do these fit within the NPT model which apperas to only deal with individuals and how they egnage or act with others. Is this a failure within the NPT model to take account of the organisational and structural determinants? In many ways these seem more of a barrier than individual behaviour as they may be less amenable to intervention in the way this project was conducted via processes of meetings and exchange.

The authors should review their interpretation and application of reflexive monitoring. They have interpreted this as monitoring individual patient outcomes which in my view is a very (medical) reductionist application. Should this not have been reflexive monitoring of the process of implementing stepped care or why not reflexive monitoring of the use of stepped treatment by professionals? The qualitative data should have been used to elicit examples of reflexive monitoring to show that mechanism in action as driving change (not predefine reflexive monitoring).

Discussion
Would stepped care implementation/up-take by GPs have occured by itself if
local services had been developed for low intensity treatment as alternatives to antidepressants - or did it really require the coherence and cognitive participation to deliver these and their up-take? The failure of stepped care’s wider implementation may be the lack of alternatives in many locations and little else.

How realistic is it to implement this project more widely? And how succesful was the project given that some could not reach coherence? I feel there should be more critical discussion overall of the success of this initiative and of the usefulness and validity of NPT rather than wholesale adoption of its concepts.

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

**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