Reviewer's report

Title: A two way street: bridging implementation science and cultural adaptations of mental health treatments

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This is an interesting paper that attempts to highlight areas of mutual relevance of implementation science and cultural adaptation intervention research. Strengths include a nice overview of dominant frameworks in each paradigm, an exposition of major areas of focus in each respective area that highlights areas of possible intersection. As it is currently written, the goal appears to be to orient researchers in the two separate areas to tenets emerging from the other. I wonder whether, given the intent to publish in Implementation Science, the paper would be better framed in terms of what implications cultural adaptation research has for implementation science. But I understand if this is not the author's main goal. Another general impression is that the paper seems to offer few specifics of implications of findings in one area for recommendations for the other, and few specifics for the integration of research agendas. The following are more specific issues I noted that all comprise - Discretionary Revisions:

1. I would caution the authors to avoid asserting overgeneralized/untested claims regarding cultural adaptation. For example, they note that surface modifications are required for feasible dissemination, that is - a prerequisite (p.11). This is likely true for language translation of print materials, but other surface modifications are probably not in the category of absolute necessity for dissemination and have not necessarily been shown to improve engagement or clinical outcomes, in and of themselves (e.g., depicting ethnically representative individuals in audio-visual materials).

2. Related to the above concern, the authors should explain with more clarity the demonstrated effects and potential value of cultural adaptation for implementation outcomes. They cite the Bemish et al. (2011) meta-analysis, and it is unclear what point is being asserted here: “Recent meta-analysis shows that the most effective treatments are those that are adapted to the target population”. This paper presents an analysis indicating that there is support for relative efficacy of culturally adapted versus standard EBTs. However, there is considerable variability in effect size estimates across studies, and other meta-analytic work does not support the argument for relative efficacy (e.g., Huey & Polo, 2009; and some published trials). It is probably important to acknowledge mixed findings and to indicate that some questions remain about the relative efficacy question. Yet, this question may not be central to the relevance of cultural adaptation for implementation science. Rather, for implementation science, it is probably more crucial to know whether
implementation of cultural adapted interventions would result in differential adoption, fidelity, and sustainment. As far as questions of efficacy, it might important to assert instead that culturally adapted EBTs are robust in terms of treatment effects as large as standard EBTs, when they avoid diluting or subtract core components of EBT models.

3. A major difficulty I see in how cultural adaptation may be relevant to implementation science is that the methods and models presented as emerging from the literature seem totally impractical in community practice settings. The type of deliberate, sequenced data collection and iterative piloting and development (p. 8-9) seems untenable in the context of moving something to scale in the field. It is the same problem all over again of assuming that things that happen in efficacy settings can be replicated at scale in practice settings.

4. The authors argue that incorporating methods from cultural adaptation research can inform what types of modifications can be made to interventions without compromising fidelity. I’m not convinced that cultural adaptation researchers or intervention scientists, in general, have this all figured out. The authors seem to assume that treatment developers are in a good position to know what is core and what is modifiable in their interventions to maintain effectiveness (p.10). However, some times developers are not amenable to changes in their protocols for reasons other than having data on what components are necessary to outcomes. What if developer’s notions of what is core and what is adaptable have not been subject to empirical test? This speaks to the maturity of intervention science in informing implementation science.

5. It seems that cultural adaptation of the intervention is but one subset of the multiple types of adaptations that can occur when an innovation is adopted and implemented. This is a type of adaptation that happens generally at the level of the features of the intervention (typically operationalized as modifications to a manual/protocol). In the end, this may be a very narrow way of approaching cultural adaptation that could be shifted if an implementation science lens was adopted. Adaptations to improve fit between the innovation and the practice setting might include provider-level (training for engagement of difficult to reach client populations) or organizational targets (changing client flow protocols for managing waitlists, referrals, or community outreach). Perhaps these distinctions can be made explicit.

6. Related to the previous point, the authors focus a good deal on outer contextual factors that include community level norms and attitudes toward mental health targets and treatments. To a large extent, what we know from cultural adaptation of interventions typically does not directly address these community level factors. I agree that community participatory methods can inform the adoption and implementation of EBTs, but this is not necessarily unique to cultural adaptation research, nor are community participatory activities always going to lead to the tailoring and modifying specifics of the content or process of the interventions themselves. True CPBR may best applied to selecting what problems are going to the matter of focus to begin with and what class of EBTs (if any) might be adopted. Furthermore, I think it is important to keep in mind that the
level of modifications typically undertaken in cultural adaptation can usually affect engagement only once individuals have a first contact with the provider. Tailoring intervention content and process can have little to no impact on whether providers are able to get culturally diverse community members into the door in the first place. As a matter of fact, in some of the practice contexts in which implementation efforts are occurring, getting consumers in the door is not the major challenge – instead there may be waiting lists and higher than desirable caseloads, but attrition may be the problem. So it might be good to clarify what types of implementation outcomes can best supported by cultural adaptations. For example, at the organizational or provider level is the availability of a culturally adapted version of an EBT going to be relevant for adoption or implementation outcomes?

7. In many respects, I think the paper discusses implementation processes as ideal, providing models that sound like best practice implementation with a good deal of pre-implementation preparation and intensive support and planning for adaptation and mechanisms for feedback and iterative changes. It might be good to give some attention to the fact that, as with the efficacy and effectiveness continuum in intervention science, there is likely to be a lot of daylight between ideal implementation conditions and implementation as usual. I think the treatment of the topic of integrating cultural adaptation and implementation science is missing the other usual context.

**Level of interest:** An article of importance in its field

**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 declare I have no competing interests.