

COMPUTERISED COGNITIVE BEHAVIOURAL THERAPY (cCBT): EVALUATING cCBT SERVICE MODELS IN THE NHS AND THIRD SECTOR

Informing World Class Commissioning in Primary Care

Care Services Improvement Partnership:
North West Regional Development Centre

Part of the 'Stepping Up' Programme:
Improving Access to Psychological Therapies in the North West

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of Public Health & Service Providers

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NHS Trust; Newcastle PCT; North Yorkshire &
York PCT (Adult Psychology Service & Harrogate
Primary Care Mental Health Service); North
Lincolnshire PCT; HMP Askham Grange.

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(D)EPRESSION SERIES: A NOTE FROM THE SERIES EDITOR

This report is the third publication of the D-Series, promoting emerging evidence and outcomes from the 'Stepping Up' programme delivered by CSIP North West Development Centre.

In this publication, we have worked with colleagues from North East Yorkshire & Humber to evaluate the roll-out of cCBT across the North of England.

Over the past two years, the D-Series has attracted national and international interest by providing honest and critical intelligence from front line services. The series is primarily concerned with reducing health inequalities; improving the well being of individuals who receive support in Primary Care for common mental health problems such as depression and / or anxiety.

This third and final report enables Commissioners in Primary Care Trusts to utilise World Class Commissioning competencies when procuring cCBT services:

Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration (WCC Competency 8).

The findings offer Commissioners key learning on the 'boosters' and 'blockers' to the effective implementation of cCBT. The recommendations outline a range of factors which accelerate innovation and improvement, as well as highlight the risks, barriers and slow down factors which affect implementation.

Finally, as Series Editor of the D-Series, I would like to offer my thanks to readers and contributors to the series. Please keep in touch with all the latest developments on the National Improving Access to Psychological Therapies programme at www.iapt.nhs.uk



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November 2008

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INTRODUCTION

This report evaluates the implementation and provision of cCBT service models (Beating the Blues®) across a range of NHS and Third Sector services in the North West, North East and Yorkshire & Humber regions of England.

What is cCBT?

Computerised CBT represents an alternative form of therapy delivery that has the potential to increase access to CBT. This project used 'Beating the Blues', a commercially produced computerised cognitive behavioural therapy (cCBT) programme for depression and anxiety that is available via CD-ROM and the Internet.

In 2006 the National Institute of Health and Clinical Excellence (NICE) recommended Beating the Blues as a treatment option for all people seen with mild or moderate depression.

Why evaluate the roll-out of cCBT service models?

NICE Guidance advises Primary Care Trusts to make available cCBT for people experiencing common mental health problems such as depression.

Between 2004-06, regional intelligence suggested that uptake and provision of cCBT varied across PCTs. Clinical leads and Commissioners also had mixed views on how to utilise cCBT as an evidence based intervention.

As part of 'Stepping Up', this report outlines emerging evidence on the strengths and limitations of models for implementing cCBT, aiming to develop cost effective and high quality care across local communities.

Readers are asked to note, that whilst clinical outcome data has been provided on the service model for Self-Help Services this report is not primarily interested in the clinical effectiveness of cCBT, which has previously been reviewed by NICE.

Methods

Participating sites were selected by CSIP Regional Development Centres following an expression of interest from sites that had a keen interest in providing and implementing cCBT.

Data collection

Three strands of data were collected:

- Service descriptions/models
- Individual semi structured interviews with service providers either via face to face or by telephone
- Service activity data

A summary of each service participating in the cCBT evaluation is provided in the main body of the report, along with a brief outline of each of the varying service models as well as the strengths and limitations of the cCBT delivery model.

EXECUTIVE SUMMARY

Key findings

Commissioning for the whole community: improving access to treatment for common mental health problems through cCBT

As leading edge early adopters of cCBT, these services implemented a new aspect of their stepped care service provision - managing to set up and deliver diverse models of cCBT over a 6-8 months timeframe¹.

1. Workforce & clinical

Workforce buy-in to cCBT is critical to successful implementation: Staff attitudes varied across participating sites and the identification of 'champions' accelerated the implementation of cCBT. This suggests workforce training in cCBT is critical in promoting access and referrals for cCBT support.

Managing risk: The identification and management of perceived risk was highlighted as a potentially difficult issue in the initial stages of implementing cCBT. Consideration of how cCBT models are embedded into clinical governance structures and workforce development needs is central to delivering quality care.

2. Service models

No single model of success: The evaluation demonstrated that cCBT can be delivered in a range of service settings, with particularly successful take-up in community and Third Sector services, involving facilitators who have previously received support for mental health problems.

Complementing existing service provision: cCBT was found to have a 'good fit' with existing service models by being integrated into the stepped care model as a low intensity (step 2) intervention.

Reducing experiences of stigma: cCBT models based in the community sector also have the potential for people to receive support earlier

in the onset of personal distress - in view of traditionally longer waiting times for psychological therapies in the NHS. For example, self-referral routes offer people the choice of accessing support directly and discreetly. For some, this may reduce the potential feelings of stigma or anxiety in visiting mental health services.

3. Developing markets and managing demand

Planning, logistics and implementation:

Logistical and/or practical issues (such as workforce capacity, computers and space) which were not identified and addressed prior to implementation caused difficulties with implementation. Ensuring adequate levels of capital investment is pivotal to establishing robust service models and quality care.

Developing the market: cCBT also offers Commissioners an opportunity to develop local service provider markets. For example, community and Third Sector services can complement Primary Care Services in the NHS, by offering low intensity interventions such as cCBT with the potential to reduce demand on mental health services.

Increasing service capacity: In principle, cCBT multi-user models have the potential to increase the capacity of services, providing greater volume in Low Intensity interventions (i.e. where more than one cCBT is running at a time under supervision - for example from Graduate Mental Health or Low Intensity IAPT Workers).

Recommendations

1. Integrated models of care: cCBT services should be integrated into existing Primary Care Mental Health Services and psychological therapy services. For example Third Sector organisations delivering stand alone cCBT services need clear pathways into Primary Care Services in case people require further support or more intensive interventions such as CBT. cCBT service models are most effective when commissioned with clear policies, procedures, risk protocols and pathways, in collaboration with all stakeholders.

2. Receiving cCBT at the right time: In particular, referral agents such as GPs need to understand when to refer people to low intensity interventions such as cCBT, as opposed to high intensity interventions/psychological therapies. cCBT models aligned to guidance on the use of clinical assessment scales can ensure appropriate referrals, reducing both demand on services and wasted time for people requiring support.

3. Self-referrals: Offering cCBT via self-referrals may improve access to support for a broad cross section of the community. Many people may be comfortable presenting to their GP when experiencing common mental health problems. However, PCTs should commission equality impact assessments to understand the specific access needs of communities and the potential added value self-referral routes may offer.

4. Facilitating organisational cultural change: cCBT models may be challenging for the local workforce, for example if they traditionally offer psychological therapies face to face. Staff at all levels within the service should be encouraged to raise concerns and services should be proactive in addressing any potential fears with regards to incorporating cCBT into current provision.

5. Multi-user models: The implementation of a multi-user approach enables more than one licence to run at any one time under supervision of an appropriate worker. This is an efficient and effective model offering higher volume than one to one models, with the potential for increased cost effectiveness. Commissioners should be mindful that whilst some people may be comfortable in multi-user environments, where elements of peer to peer support may emerge, one to one provision should also be offered.

* The multi-user cCBT model in this evaluation was provided by Self Help Services (Manchester cCBT Service) see page 13-14.

6. Use of community spaces: With an ever increasing demand on GP surgery space and NHS buildings, the use of appropriate and well resourced community spaces such as libraries or quiet cafes with computer access are a viable option for cCBT models. Choice should also be maintained for people who prefer one to one support in preference to multi-user environments.

OVERVIEW

cCBT evaluation aims

1. To evaluate the implementation and provision of service models of cCBT (Beating the Blues) across a range of service providers.
2. To understand what 'boosted' the usage and uptake of cCBT service models, as well as the 'blockers' or barriers to successful implementation.

Methodology

Participating sites were selected by each of the CSIP regional Development Centres following an expression of interest from sites' organisations that had a keen interest in developing provision for psychological therapies. Third sector providers participating in this study such as Self-Help Services were selected as they had previously developed an innovative model of mental health provision which they were keen to expand to include the use of cCBT.

Data collection

Three strands of data were collected:

1. Service description

A description of the service and provision of cCBT was provided by the service manager through a face to face or telephone Interview.

2. Examination of 'boosters' and 'blockers'

To implementing cCBT were collected via individual semi structured interviews with service providers (either face to face or by telephone). All eight participating services nominated an individual responsible for service delivery who were interviewed on areas such as:

- The process of delivering cCBT within their service
- Levels of support provided within model of delivery
- Workforce mix employed within model of delivery; accessibility of service;
- Environment of delivery including location/context
- 'Boosters' and 'blockers' to cCBT implementation
- See interview schedule in appendix on page 19

3. Service activity data

All participating services were asked to provide service activity data on a monthly basis utilising a spreadsheet developed for this purpose (see appendix on page 17-18)².

SERVICE MODELS

A summary of each service model participating in the evaluation is provided below. This includes a brief outline of each of the varying service structures as well as the strengths and limitations of cCBT delivery³.

Self Help Services (Manchester)

Established in 1995, Self Help Services is a user-led mental health charity comprising of a staff team of 2.5 workers and a large, diverse and experienced volunteer team of over 70 individuals, who have personal experience of a mental health problem.

Self Help Services provides a range of support interventions for people experiencing mental health problems, including Support Groups (e.g. anger management; social skills; anxiety; depression) and a Primary Care Mental Health Service. Based at community locations, services can be accessed via self or professional referral.

Service strengths:

- cCBT is provided at a community café within a community centre. This, alongside, self referral routes makes the service easily accessible to members of the local community.
- Utilises a multi-user environment, with supervision provided by one facilitator across four computers and cCBT licences running at one time.
- People utilising cCBT have easy access to a wide range of services provided by Self Help Services due to services being provided on one site and easy access to other non-statutory services, i.e. self-help & support groups.
- The cCBT service is staffed mainly by trained volunteers who have experience of using cCBT as clients, promoting social inclusion and user involvement.
- The multi-user environment, with one facilitator means the service can achieve both quality of care and increased economies of scale.

Service limitations:

- During this evaluation, Self Help Services did not have direct access to NHS services for people who may require more intensive forms of intervention and referrals have to be made via GPs.

North Yorkshire & York PCT (Harrogate Locality)

The Primary Care Mental Health Service was established in October 2001. The service is a primary care based mental health service, which provides assessment and interventions for people with mild to moderate mental health problems.

The service offers a variety of guided self-help interventions and patient choice dictates the mode of guided self-help delivered. Examples include: group anxiety management courses, counselling, Stresspac™⁴ and guided self-help which can be face-to-face, over the telephone or via Beating the Blues. The service also offers 12 sessions of psychological therapies at Step 3 (High Intensity) of the stepped care model.

Services are provided within GP surgeries and a clinic based in a business park in a rural area of Knaresborough (Firecrest House). cCBT is also available at the public library in the centre of Knaresborough.

Service strengths:

- Continuity of care across steps 2 and 3 for more intensive psychological therapy provision when necessary.
- Services are provided at a variety of locations to increase client access.
- Staff delivering cCBT are keen and motivated about the intervention, which has increased the integration of cCBT into the existing service model.
- Staff are able to turn to other clinical work during cCBT sessions.

Service limitations:

- The rural location of one of the services is not well served by public transport.

Middlesbrough PCT

The Primary Care Team was established in 1999. Clients may be referred by their GP to a Community Psychiatric Nurse or Graduate Mental Health Worker (GMHW), attached to the surgery for short-term work such as Cognitive Behavioural Therapy.

cCBT is offered by GMHWs as one aspect of wider service provision and GMHWs attend for the introductory session only. Thereafter the practice receptionist facilitates the service. The cCBT service is provided at two GP practices in the locality.

Service strengths:

- The service is accessible for clients as it is provided at their own GP surgery (2 GP surgeries agreed to be pilot sites for cCBT implementation).
- The support of the administration team at each GP practice.

Service limitations:

- The GP surgeries piloting the cCBT service will not accept clients who are not registered patients.
- Lack of GP engagement across the PCT area during the evaluation, as only 2 GP practices agreed to pilot the implementation of cCBT.

North Yorkshire & York PCT (Bootham Park)

The service has been in operation since the 1970s. The Adult Psychological Therapies department is an integrated, multi-disciplinary service. The cCBT service is provided by a dedicated Assistant Psychologist accommodated in a clinic at The Old Chapel, Bootham Park Hospital.

Service strengths:

- The service has a dedicated assistant psychologist that provides cCBT.

Service limitations:

- Limited accessibility due to pressure on space at the premises.

North Lincolnshire PCT

The Primary Care Mental Health Service in North Lincolnshire PCT was established in June 2005.

The team is composed of nurses, a CBT therapist, Social Workers, Graduate Mental Health Workers and counsellors. They deliver a range of low intensity interventions (step two). The cCBT service is housed in the Psychological Therapies department and facilitated by administration staff, who have access to a clinician at all times.

Service strengths:

- Range of therapies available that promote client choice

Service limitations:

- The service perceived client limitations with regards to computer literacy, which impacted on the accessibility for clients.

Newcastle PCT

The citywide Primary Care Psychology service was established in 2004. The service provides a primary care mental health service, consisting of a one-to-one psychology service and a range of step 2 - low intensity interventions. For example: facilitated self-help, classes for stress control, anger management and managing mood / depression. cCBT is also provided and delivered by Assistant Psychologists from four locations across the city.

Service strengths:

- Range of therapies available
- Engaging a high proportion of male clients (a previously under-represented group)
- Access to and availability of Assistant Psychologist

Service limitations:

- The same computer hardware (printer and computer) must be used at each of the four locations, which can cause logistical problems such as collecting clinical outcome data.

Key learning - less successful implementation models

Service activity data was collected from 6 of the 8 services that initially took part in the evaluation. The remaining 2 services were unable to provide data, and cCBT was less successfully implemented. These services encountered difficulties with implementing their chosen model of service delivery for cCBT. A summary is provided in the appendix on page 19-20 offering critical learning for service providers and commissioners.

IMPLEMENTATION: 'BOOSTERS & BLOCKERS'

Exploring the 'boosters and blockers' to implementing cCBT within the NHS and Third Sector

A discussion of the emerging themes from the interviews conducted with service providers is offered below, with a focus on what 'boosted' the usage and uptake of cCBT service models, as well as the barriers or 'blockers' to successful implementation.

Staff attitudes to cCBT

When asked about personal attitudes towards the use of cCBT, interviewees described the initial scepticism of some staff. Generally there appeared to be a mixture of both positive and negative outlooks during the early stages of implementation. There was also emerging evidence of enthusiastic early adopters and, in two cases, 'champions' of cCBT. This led to other staff members 'coming round' to the view that cCBT has a valid place within the stepped care model.

Integration of cCBT within existing service models

Staff felt that the intervention was especially useful for those people who may not access individual therapy. For example, cCBT's usefulness for depression and mixed anxiety/depression would enable services to access 'untapped groups' such as male clients. Overall there was a firm consensus amongst interviewees that the cCBT intervention had worked well, within the stepped care model and offered people choice as part of a menu of support options. This resulted in cCBT being offered to an increasing number of clients. However, there were a couple of caveats:

- Identifying people who would benefit most from cCBT as distinct from other step 2 interventions such as self-guided help.

- Low uptake of cCBT within some service models and the need to revise awareness of the intervention.

Logistical and practical concerns

A number of logistical and practical difficulties were encountered during the process of delivering a cCBT service:

- Logistical problems (e.g. travelling with equipment and marketing of the service).
- Varying scepticism amongst some primary care mental health workers regarding the time taken to deliver cCBT (longer than expected) and logistical problems such as pressure on premises.
- The licensing arrangement (1 license per personal computer) was viewed as quite limiting and resource intensive.
- Issues relating to clients' lack of basic IT literacy skills coupled with the common problem of people forgetting their usernames and passwords were also mentioned.

New licensing arrangements for Beating the Blues are now in place and the programme can now be accessed via the internet or via multiple desktop computers.

Risk

A number of concerns were initially raised with regards to the identification and management of risk. For example:

- Due to the relatively 'free-standing' nature of this intervention, professionals would not have detected risk data early enough and therefore risks may not have been managed effectively.
- In practice, following the implementation of cCBT, if any risks were identified following a check of the person's progress report, a GP or other Qualified Health Professional was contacted. If no clinician was immediately available, people were followed up within one hour⁵.

Support for people using cCBT

The majority of people's support needs fell into the following categories:

- 'Technical support' such as issues with utilising Desktop computers and/or printers etc.
- 'Programme issues' these tended to relate to the tasks required of the clients when using the Beating the Blues programme.
- 'Emotional support' promoting people's self-confidence in using cCBT. As one professional comments, "Clients like to know that it is available, but don't tend to use it".

Role of workers in the cCBT process

A description of staff activity with clients before, during and after cCBT sessions:

Telephone opt-in process

At first appointment clients were taken through the log in procedure

Workers would watch the introductory video on the first session, meet their client, log them onto the system, provide them with some refreshments and give them information on how to contact staff (mostly by telephone) if they required any further assistance.

During cCBT sessions

Staff were contactable by telephone and, in most cases, were situated in the next office or nearby.

Technical support was readily available and provided by administrative staff.

If people raised clinical issues, a qualified health professional would be called.

When cCBT was used where clinical staff were not readily available, arrangements were in place to inform people's GPs if necessary.

Following cCBT sessions

Staff printed off the person's progress report, checked for any risks and answered any additional questions.

Most staff allocated approximately 10 minutes per person to these post-session activities.

If any risk was identified, a GP and/or other member of the clinical team would see people immediately.

In addition, whilst the cCBT sessions were taking place, staff described being able to continue with their normal work (e.g. delivering guided self-help, administration, and research/reading).

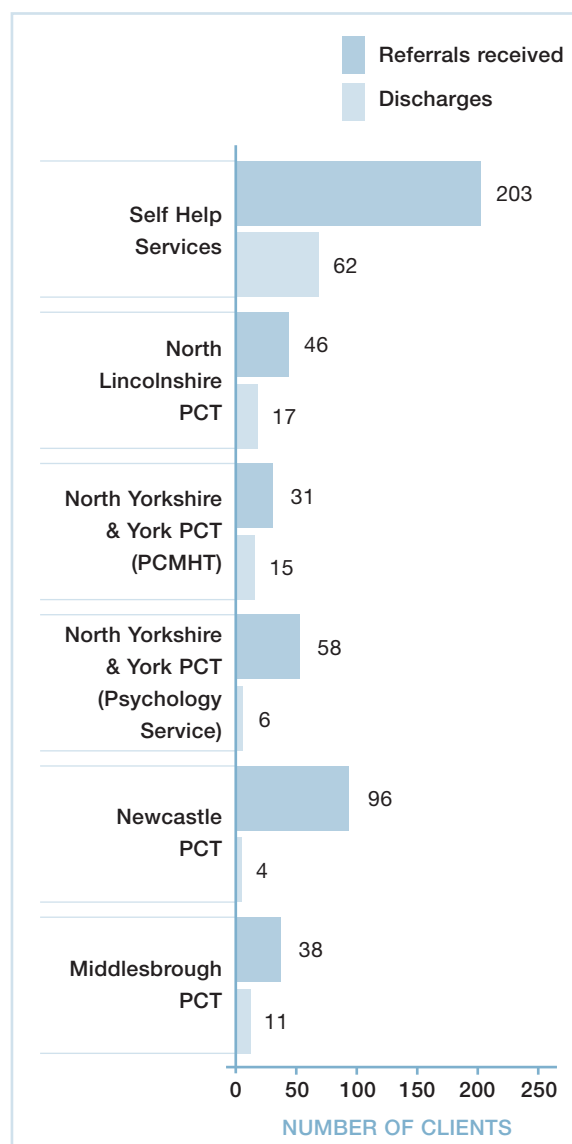
SERVICE ACTIVITY & CAPACITY

6 of the 8 services participating in the evaluation provided 6 months of service activity data. A conservative interpretation of findings should be made due to the small sample size.

Summary

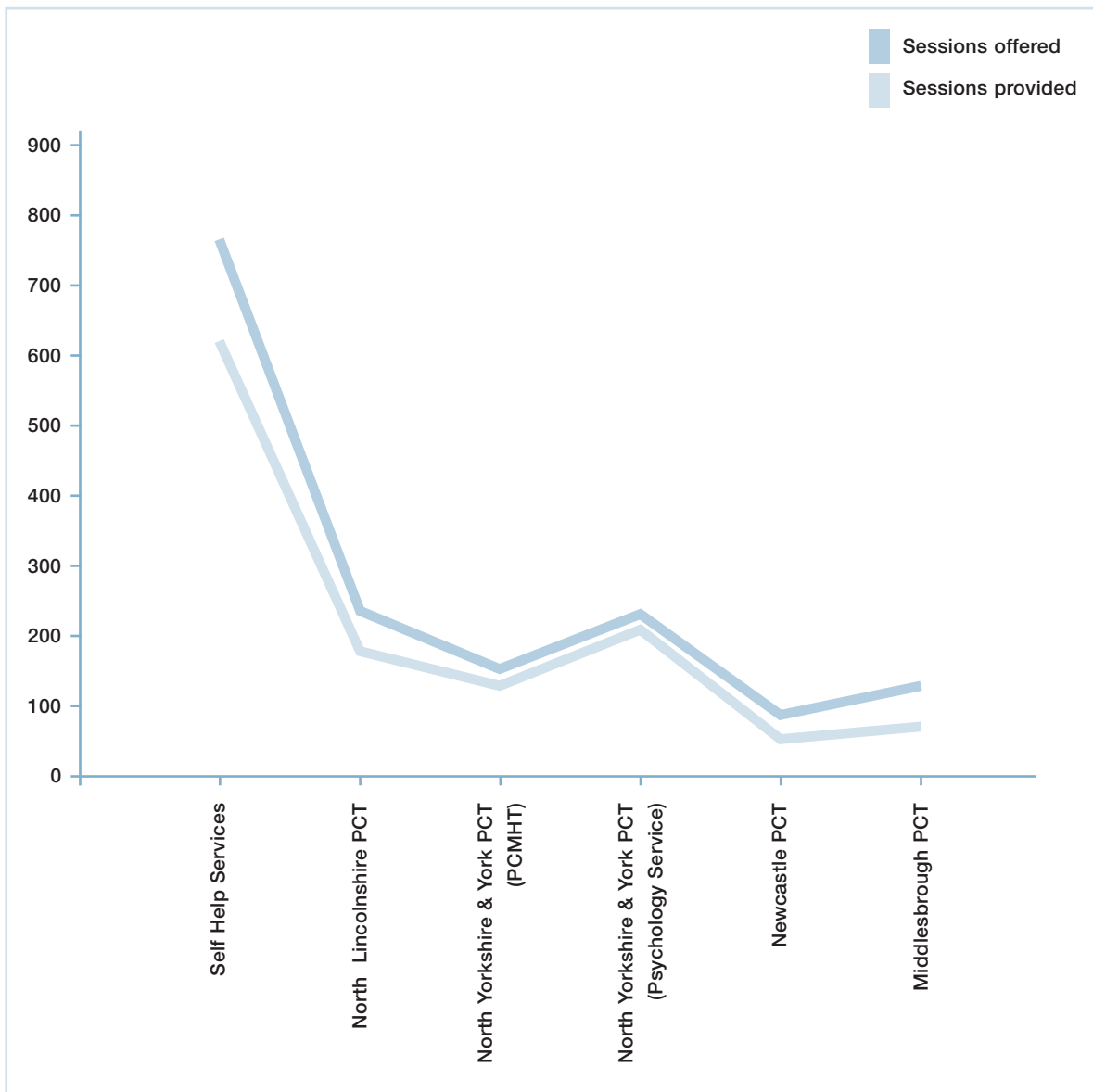
Figures 1 & 2 below provide a summary of referrals and discharges made over a 6-month period as well as a summary of the number of sessions offered and provided⁶. Of the 6 services that provided service activity data a total of 472 referrals were made for cCBT, and of these 115 were discharged. The overall attrition rate across all services providing data was 22%. More detailed information relating to service activity can be found in the appendix on page 17-18.

Figure 1
Summary of referrals and discharge



As Figure 1 highlights, Self Help Services' multi-user model accounted for 43% of the overall number of referrals received across all participating sites, with an uptake of 79% of all sessions offered.

Figure 2
Summary of sessions offered and sessions provided (i.e. that the client attended)



SERVICE SNAP SHOT: cCBT MODEL - SELF HELP SERVICES (MANCHESTER cCBT SERVICE)

This section provides a summary of the service model, as well as a profile of clients accessing the service as well as a summary of clinical outcomes.

Service Summary

- Maximum of 8 cCBT sessions averaging 50 minutes each, to people affected by depression and/or anxiety.
- Sessions are available in the daytime and evening
- Support for clients is provided by Volunteers who have experience of using the service
- Waiting times from referral to treatment average at 1 week
- 21% Did Not Attend rate (DNA)

Client Profile

Summary profile of 203 clients accessing the service.

Client profile	Count of referrals	% of referrals (N = 203)
Black Minority & Ethnic Communities (BME)	28	14%
Refugees	1	0.5%
Asylum seekers (NASS support)	0	0%
Employed	60	26%
Unemployed	23	11%
Long-term sickness	8	4%
Self-employed	4	2%
Retired	4	2%
Student	19	9%

Summary: 14% of people accessing the service were from BME communities. 26% of people were in employment.

Service Activity (February - July 2007)

Figure 3
Comparison of referrals and discharge
(Self Help Services)

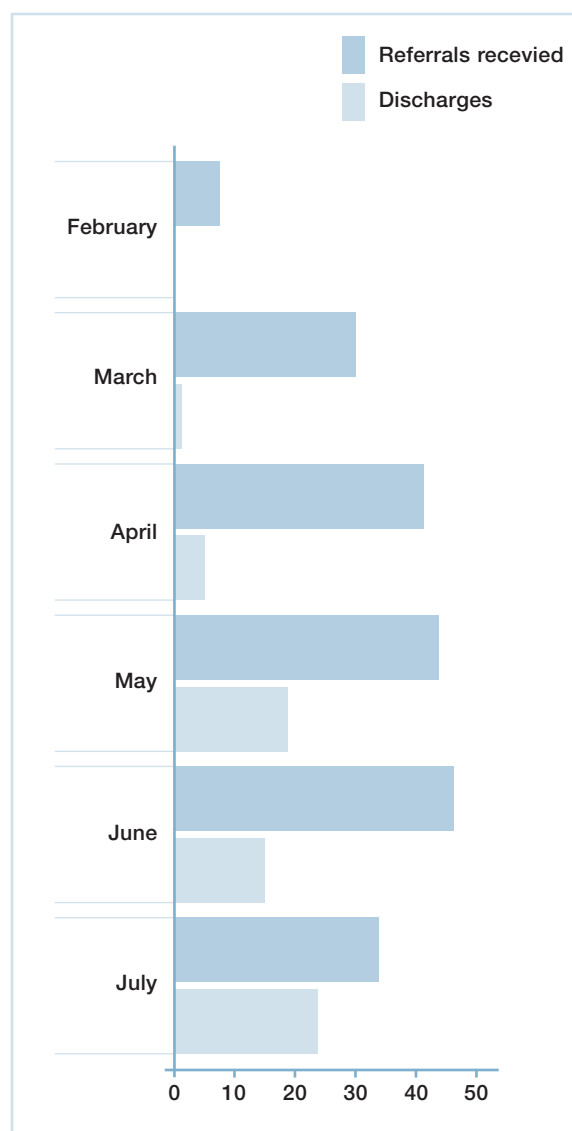
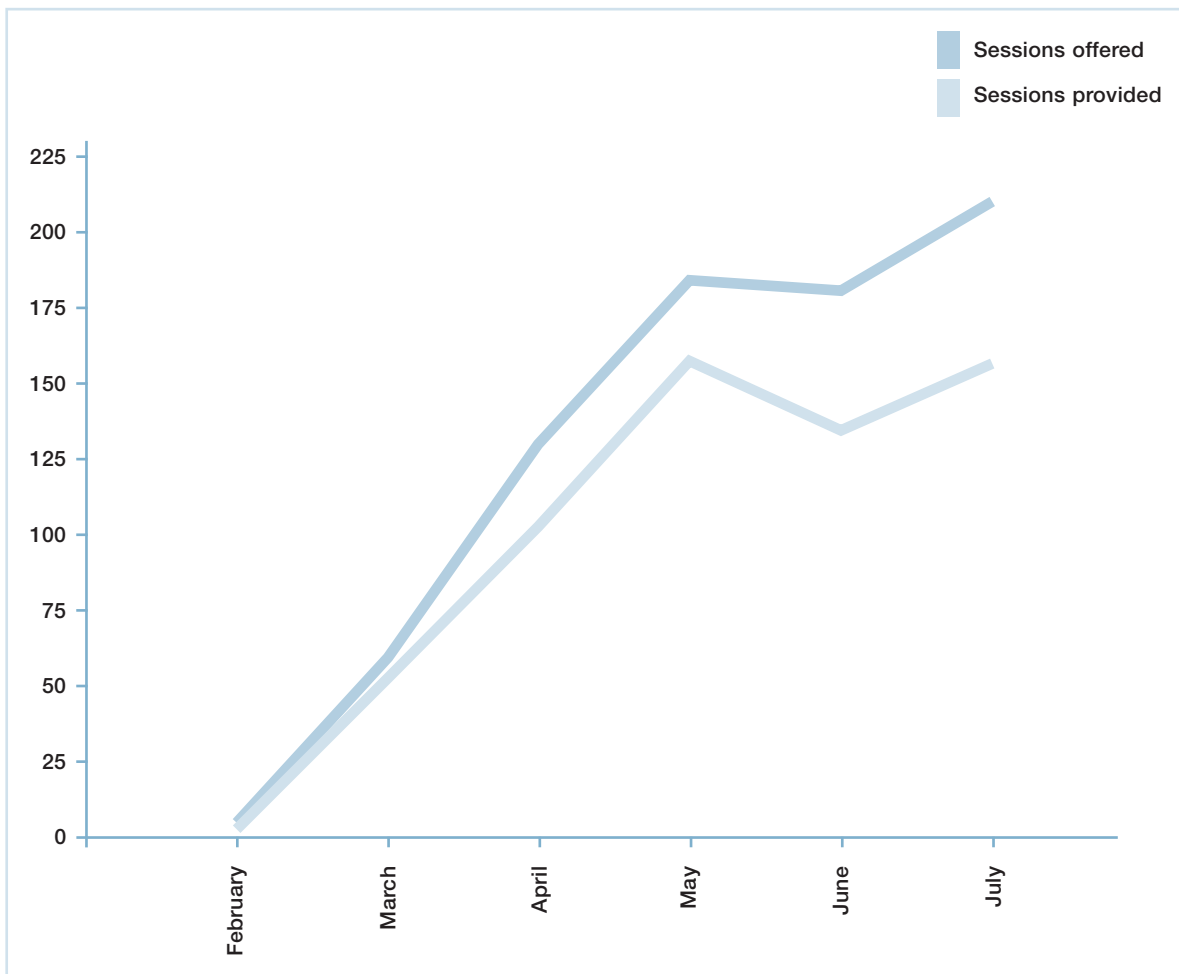


Figure 4
Comparison of sessions offered and sessions provided (Self Help Services)



Clinical Outcomes

Two types of clinical data sets were collected for people using cCBT:

- PHQ-9
- CORE-OM

Summary of CORE-OM

For the period February - July 2007, Self Help Services collected CORE-10 scores pre and post cCBT intervention for 78 people.

44 of the 78 experienced reliable and clinically significant improvement. This means a client beginning therapy with a score that classifies them as being in a clinical population and ending therapy with a score that places them into the non-clinical population. Consideration should be given to the relatively low completion rate (approx 40%) and caution is advised when interpreting results.

- Pre-therapy, average CORE-OM scores ranged from 0.29 to 3.28. Post therapy scores ranged from 0.07 to 2.39. Table 2 below provides a summary of the CORE-OM findings.
- It is important to note that this is a small sample size and therefore results should be interpreted conservatively.

Summary of reliable and clinically significant change

	All clients (N = 78)		
	Male (N = 32)	Female (N = 46)	Total per improvement category
Reliable & Clinically significant improvement	13	31	44
Reliable improvement only	5	5	10
No reliable change	14	9	23
Reliable deterioration	0	1	1
Total	32	46	78

Notes

According to Jacobson and Truax (1991)⁷, achieving reliable and clinically significant improvement in psychological treatment requires a client to meet two criteria. Firstly, the pre-post improvement in scores must be large enough not to be attributable to measurement error and secondly the improvement must be clinically significant. This is usually defined as a client beginning therapy with a score that classifies them as being in a clinical population and ending therapy with a score that places them into the non-clinical population.

For the CORE-OM measure, a clinical cut off of 1.19 for female clients and 1.29 for male clients is used, where 1.19/1.29 is in the non-clinical range and 1.20/1.30 is in the clinical range. To achieve reliable change (i.e. that which could not be due to measurement error), the difference between the average total pre and post scores must be 0.5 or greater. To achieve clinically significant change a client must change from a pre-therapy average score of 1.20/1.30 or more to a post therapy score of 1.19/1.29 or below. To achieve reliable and clinically significant change both criteria must be fulfilled.

Summary of PHQ-9

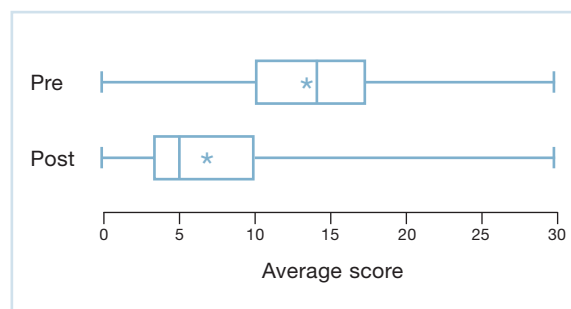
- For the period February - July 2007, Self Help Services collected PHQ-9 scores pre and post cCBT intervention for 82 people.
- Pre-therapy, PHQ-9 scores for Self Help Services clients ranged from 2 to 26 with an average (mean) score of 14. Post therapy scores ranged from 0 to 23 with an average score of 7, demonstrating an average change of 7.

Notes

PHQ-9 scores are calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," for the 9 questions included in the scale. PHQ-9 total score for the nine questions ranges from 0 to 27 and scores of 5, 10, 15, and 20 represent cut off points for mild, moderate, moderately severe and severe depression respectively.

Figure 5 below shows the PHQ-9 data in box-plot form; each box-plot gives a summary of the PHQ-9 scores for clients' pre and post cCBT intervention. The lines in the middle of the boxes are the average median scores, and the * indicate the mean average score; the boxes include the middle 50% of the data, and the whiskers include the highest and lowest 25% of the scores.

Figure 5
PHQ-9 Scores Summary (N=82)



APPENDICES

Summary of services

	Self Help Services	North Lincolnshire PCT
Service established	1995	2005
cCBT established	2007	2007
Location of cCBT provision	Community Cafe	Psychological Therapies Unit
Number of staff	0.6	3
Staff to client ratio	1:2 ⁸	1:1

Service activity data

	Self Help Services	North Lincolnshire PCT
Number of cCBT licenses	4	1
Total referrals	203	46
Max number of people waiting for cCBT (in any one month)	0	0
Average wait for cCBT	1	0
Max wait for cCBT	4	0
cCBT sessions offered	776	236
cCBT sessions provided (i.e. client attended)	610	188
Average length of cCBT session (in mins)	50	55
Average time between sessions (in weeks)	4	1
Number of people discharged	62	17
Number of people needing further support	0	1

North Yorkshire & York PCT (PCMHS)	North Yorkshire & York PCT (Psychology Service)	Newcastle PCT	Middlesbrough PCT
2001	1978	2004	1999
2007	2007	2007	2007
PCMHS Centre; Library	Psychological Therapies Department	GP surgeries; Resource Centres; Library	GP Surgeries
0.4	2	4	2
1:1	1:1	1:1	1:1

North Yorkshire & York PCT (PCMHS)	North Yorkshire & York PCT (Psychology Service)	Newcastle PCT	Middlesbrough PCT
1	1	1	1
31	58	14	38
11 (due to staff vacancies)	7	0	0
4	1	2	1
7	4	3	4
146	232	96	117
120	203	61	76
65	60	60	60
1	1	1	1
15	6	4	11
5	10	0	4

Evaluating cCBT: interview schedule

1. When was your service established and how long has the service been in operation?
2. Is the provision of cCBT your sole function or is this just one aspect (i.e. an add on) of your service provision?
3. Where is cCBT provided? Please describe the location and the environment [probe the perceived suitability - i.e. access for clients, difficulties for staff etc.]
4. How many staff deliver cCBT? Please describe their professional backgrounds (qualifications and year's experience) [probe what staff attitudes are to using CCBT]
5. What is the ratio of staff to clients at any one time?
6. Please describe:
 - (i) what staff do with each client PRIOR to each cCBT session;
 - (ii) what staff do with each client DURING each cCBT session;
 - (iii) what staff do with each client AFTER each cCBT session
 - (iv) Are staff able to turn to other work whilst the cCBT sessions are taking place?
7. In your experience, what type(s) of support do your clients need (e.g. emotional, technical etc...)
8. How are risks identified and managed on an individual basis?
9. In general terms, how do you think cCBT has worked within your service? [Probe specifically barriers and facilitators to its implementation]
10. What difficulties have you encountered during the process of delivering this service?

Key learning - less successful implementation models

The 2 services that were unable to provide data were HMP Askham Grange and Scarborough Primary Care Mental Health Service (Tees, Esk & Wear Valleys NHS Trust).

Scarborough Primary Care Mental Health Services

The main difficulties encountered by this service were related to computer hardware/software and concerns about risk.

- The initial intention was for the service to utilise the Beating the Blues programme on GP practice computers but it was decided that this was not appropriate due to concerns regarding patients potentially accessing sensitive information via networks within the surgery.
- When replacement hardware was sourced by the service, the hardware specification did not meet the software requirements, which were provided by the software provider.
- In addition, there were some difficulties with regards to the PCT IT department requirements of not installing external software package onto PCT computers. The care workers within this service also had concerns that, due to the relatively 'free-standing' nature of this intervention, professionals would not have detected risk data early enough.

HMP Askham Grange

HMP Askham Grange is a women's open prison and cCBT was provided during the evaluation period through the nurse led unit.

- Implementation of cCBT was hindered due to the transient population group and accommodation/space issues.
- Clients referred for cCBT did not always complete treatment due to the length of stay within the prison not allowing for full completion.
- In addition, the service accommodation did not have suitable desks or workstations and the location meant that it was difficult for clients to summon assistance and for staff to observe any problems or complications.

NOTES

1/2 Monthly data requested from services focussed on numbers of referrals, number of sessions offered/provided as well as discharges from service.

3 Strengths and limitations of the services were developed in partnership between the evaluation team and the service providers themselves.

4 Stresspac™ is a self-help anxiety management treatment which should be used in conjunction with therapist-directed therapy.

5 In one instance, Link workers (who mostly dealt with low risk clients) took any concerns that they had to their clinical supervisor.

6 Discharges refers to the number of people who exit the service having reached an optimum level of care).

7 Jacobson NS, Truax P. (1991) Clinical Significance: A Statistical Approach To Defining Meaningful Change in Psychotherapy Research. J Consult Clin Psychology. 59:12-9

8 Indicates ratio of clients to cCBT volunteer support workers, and not paid members of staff.



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