Improving access to psychological therapies (IAPT) programme

Computerised cognitive behavioural therapy (cCBT) implementation guidance

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Improving access to psychological therapies (IAPT) programme

Computerised cognitive behavioural therapy (cCBT) implementation guidance[1]

March 2007

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1. When using this guidance it is essential that consideration is made to the access needs of all groups that may benefit from cCBT.

Contents

Foreword

I welcome this document as a key milestone in the delivery of the Department of Health's Improving Access to Psychological Therapies programme.

It gives valuable advice and timely guidance on how primary care trusts (PCTs) may provide computerised cognitive behavioural therapy (cCBT) to their local communities.

NICE Technology Appraisal TA097 published in February 2006, recommended the use of specific cCBT products for the management of mild and moderate depression as well as panic and phobia. PCTs are expected to be able to offer these products by 31 March 2007.

Providing cCBT will underpin two key principles of the IAPT programme: promoting choice and expanding access to talking therapies.

Choice will be improved by providing people with another treatment option, allowing them to take greater control of when and where therapy is delivered. Access to services will be expanded by increasing the possible locations where therapy can be delivered, especially non-clinical ones such as libraries.

The potential benefits to society and individuals are great but there is a long way to go. Fundamental to this challenge is to make people better and I believe that the provision of cCBT will help achieve this end.

This document provides us with an invaluable tool by which the NHS and practitioners may start to provide a clinically effectual and cost effective treatment through an innovative medium.

Louis Appleby
National Director for Mental Health

Introduction

This guide has been developed to help the NHS as they make decisions about the implementation of the National Institute for Health and Clinical Excellence Technology Appraisal TA097.

Summary of NICE recommendations and DH guidance for the Use of Computerised CBT (cCBT) in the NHS

The NHS is legally required to fund and resource medicines and treatments recommended by the National Institute for Health and Clinical Excellence (NICE) Technology Appraisal (TA) reviews[2]. In February 2006, NICE published a technology appraisal on the use of computerised delivery of cognitive behaviour therapy (cCBT). In summary, the technology appraisal provided background information on cCBT and the management of people with common mental health conditions for whom this type of intervention is appropriate. The appraisal recommended:

- **"*Beating the Blues*®" as an option for delivering computer-based cognitive behavioural therapy (cCBT) in the management of mild and moderate depression**

- **"*FearFighter*™" as an option for delivering computer-based cognitive behavioural therapy (cCBT) in the management of panic and phobia**

In a communication to PCT Chief Executives (November 2006), Professor Louis Appleby, the National Director for Mental Health, confirmed the NICE recommendations and stated that PCTs are expected to be able to offer the recommended cCBT programs by 31st March 2007. In order to achieve this goal, PCTs are expected to:

- Undertake a local needs assessment

- Purchase software licences

- Ensure the availability of hardware for the delivery of packages

- Ensure that appropriately trained staff are available to supervise delivery

- Develop referral protocols

The full letter can be found at: http://www.mhchoice.csip.org.uk/psychological-therapies/computerised-cognitive-behavioural-therapy-ccbt.html

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2. http://www.nice.org.uk/page.aspx?o=282358

Mental health conditions for which computerised CBT (cCBT) may be indicated

1. Depression

Depression is a common mental health condition that the WHO has indicated will be the second most common long term condition world wide by 2020.

The diagnosis of depression is based on the presence of a number of symptoms described in the 10th version of the International Classification of Diseases (ICD). A depressive episode is diagnosed if at least two out of three core symptoms have been experienced for most of the day, nearly every day for at least two weeks.

The core symptoms are:

- Low mood (feeling low, unhappy, sad or miserable)

- Fatigue (feeling tired or having little energy)

- Anhedonia (lack of interest or enjoyment in things)

The disorder is further sub-divided into mild, moderate, severe, and depression with psychosis, depending on the number of symptoms present.

The NICE guidelines for the management of depression were published in December 2004 and recommended a "stepped care" approach with the severity of the depression requiring different interventions. For example, the guidelines recommend that medication is not usually prescribed for people with mild depression.

The prevalence of depression has been estimated to be 2.6% of the population and the prevalence of mixed anxiety and depression has been variously estimated as between 5.5 and 8.8% of the population. The NICE Guidelines for Depression, and those for Anxiety, clearly indicate that where mixed anxiety and depression symptoms are apparent, then the NICE Guidelines for Depression should be followed. A tool for estimating demand has been developed to assist in determining the requirements for the provision of cCBT for their local population. This is not a needs assessment tool.

An outcome of the 2006 review of the new General Medical Service (nGMS) contract for primary care has been the introduction of a Quality and Outcomes Framework (QoF) indicator for depression that incentivises the use of approved questionnaires to assess severity of the condition[3].

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3. Quality and Outcomes Framework (QOF)[4] guidance p. 141 et seq.

The NICE technology appraisal (TA097) recommended the use of **Beating the Blues**® for the management of mild and moderate depression.

The Department of Health (DH) recommends the use of the PHQ-9 as a possible tool to determine the level of severity for people with depression, as well as an indicator of change in the condition. This tool is available from the cCBT resource page.[3]

2. Panic and Anxiety Disorders

Anxiety is a normal protective reaction to stress. However, if the symptoms of anxiety appear either at inappropriate times or in inappropriate situations an "anxiety disorder" may be present.

Panic disorder, **with or without agoraphobia**, together with generalised anxiety disorder represent the largest category of common mental health conditions. However, the clinical picture is often less clear, since anxiety frequently co-exists with depression. Such "mixed anxiety and depression" is an extremely common and disabling condition.

The diagnosis of panic disorder (PD) – to be distinguished from a "panic attack" – is characterised by the presence of recurrent, unexpected panic attacks followed by at least one month of persistent concern about having another panic attack, worry about the possible implications or consequences of the panic attacks, or a significant behavioural change related to the attacks. Panic in and avoidance of public places is a major feature and the main source of disability.

'Generalised anxiety disorder' (GAD) is diagnosed after a person has on most days for at least six months experienced prominent tension (increased fatigue, trembling, restlessness, muscle tension), worry, and feelings of apprehension about everyday problems. The person is anxious in most situations and there is no particular trigger for anxiety.

The NICE guideline for the management of GAD and PD, also published in December 2004, recommended that effective interventions were medication, CBT or bibliotherapy.

The NICE technology appraisal (TA097) recommended FearFighter™ for the management of panic.

The DH recommends the use of the GAD-7 (derived from the PHQ-60 questionnaire) as a possible tool to determine caseness for the range of anxiety disorders, as well as an indicator of change in the condition.

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3   For ease of reference this webpage will be hyperlinked throughout the document

In addition to caseness, the suitability for cCBT (type of problem, absence of suicidal plans, education about the process of and motivation for cCBT) also needs to be determined[4].

3. Phobias

Phobias are a form of "anxiety disorder" and are characterised by the presence of anxiety and panic in, and avoidance of, particular stimuli e.g. public places, social contact, blood-injury, spiders.

The NICE technology appraisal (TA097) recommended **FearFighter**™ for the management of phobia.

4. Obsessive Compulsive Disorder[5]

Obsessive compulsive disorder is a common form of anxiety characterised by obsessive thinking and compulsive behaviour. Obsessions are distressing, repetitive thoughts which may be seen as irrational, but cannot be ignored. Compulsions are ritual actions which people feel compelled to repeat in order to relieve anxiety or to stop obsessive thoughts.

NICE guidelines recommend medication or CBT as effective treatment options. The NICE technology appraisal (TA097) was unable to recommend cCBT for general use in the treatment of obsessive-compulsive disorder.

5. Severe Mental Illness

a. **Schizophrenia[6]:** Whilst NICE guidelines for the management of people with schizophrenia recommend CBT as a treatment option, computerised delivery is not considered. The absence of any quoted papers on computerised CBT implies that there is little evidence in this area, and that until there is, it is probably not appropriate for general use in the NHS.

b. **Bipolar Disorder[7]:** Recently published NICE guidelines recommend the use of computerised CBT for pregnant women with bipolar disorder, who have a mild depressive disorder.

c. **Antenatal and postnatal mental health:** Recently published NICE guidelines recommend the use of computerised CBT for women who have a new episode of panic disorder during pregnancy.[8]

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4   This can be done by a valid and free self-completed Screening Questionnaire which saves clinicians much screening time (Gega et al, CBT, 2005, 34, 16-21)

5   http://www.nice.org.uk/guidance/CG31

6   http://www.nice.org.uk/42424

7   http://www.nice.org.uk/guidance/cg38/niceguidance/pdf/English

8   http://www.nice.org.uk/guidance/CG45/niceguidance/pdf/English/download.dspx

Overview of Cognitive Behavioural Therapy

Cognitive behavioural therapy is based on the premise that there is a close connection between cognition (how we think), our emotions (how we feel), and our behaviour (how we act).

There is a strong scientific and research base to support the effectiveness of "therapist delivered" cognitive behaviour therapy (CBT), in the management of people with depression, anxiety disorders, obsessive compulsive disorder, schizophrenia and bi-polar disorder. There is also a strong research base to support the use of "therapist delivered" CBT in the management of a number of long-term conditions such as chronic obstructive pulmonary disease and diabetes.

As an alternative to "therapist delivered" CBT, the recent NICE technology appraisal (TA097) assessed the evidence for clinical and cost effectiveness of **computerised CBT (cCBT)** in the treatment of a number of different clinical mental health conditions and has made recommendations for its implementation. For further information, please refer to NICE TA097 and supporting documents.

What is computerised CBT (cCBT)?

"cCBT" is a generic term encompassing a number of approaches to the delivery of CBT via an interactive computer interface. cCBT can be delivered on a personal computer, over the Internet or via the telephone using interactive voice response (IVR) systems. A wide range of health or social care personnel can be used to facilitate the sessions.

Beating the Blues®[9] is a CBT-based package for people with mild to moderate depression and anxiety. The package comprises of a 15-minute introductory video and eight 1-hour interactive computer sessions, usually organised weekly. The package also comprises of homework projects that are completed between sessions and weekly progress reports are made available to the GP or other healthcare professional at the end of each session. The progress reports include anxiety and depression ratings and suicidal tendencies. The programme, which is available on CD ROM or on-line, assumes a minimum reading age of 10 to 11 years of age.

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9   Ultrasis plc

FearFighter™[10] is a cCBT-based package for phobic, panic and anxiety disorders. The programme assumes a reading age of 11 and is available on-line. FearFighter™ is divided into nine steps with therapist contact being brief and support provided by trained support workers through 5-10 minutes telephone calls (cumulative total of no longer than 1 hour in all over 3 months), or emails at different intervals throughout treatment. Progress reports are available to the GP or other healthcare professionals and can be accessed at any time over the Internet using ST Solutions Ltd's clinical-outcome and patients progress monitoring system.

The NICE Technology Appraisal (TA097) did not review all available cCBT programmes. The advantages and disadvantages of non-reviewed programmes, including those available "free of charge" (FOC) are unclear and the provision of FOC packages do not necessarily indicate a cost-effective solution. Such products are not a substitute for the recommendations made in NICE TA097. Information can be found at the CSIP cCBT resource page.

PCTs are expected to audit their compliance against NICE recommendations. Suggested audit criteria can be found in NICE TA097, (section 7 "Implementation and audit" and appendix C.) and associated NICE guidelines for depression and anxiety.

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10 ST Solutions Ltd

Experience of using Computerised CBT

Computerised CBT has been used by a number of organisations within health and social care already, as part of research programmes, as part of the Department of Work and Pension's *Pathways to Work* programme, as part of a talking therapy services within a PCT and in many GP practices. Based on the experience of these groups, the following considerations have been developed to aid the location and use of computerised CBT.

Best Practice and Data

cCBT has been used effectively in a number of configurations within a PCT or community service. There is, however, insufficient direct comparative evidence that demonstrates clearly that one set of options is superior to another.

This means that the service has to ensure that good clinical records including outcome measures are recorded for every client/user of the system, in order to provide a basis for improving the service and to ensure that the procedures and circumstances that deliver the best results can be accurately described. Details of who is responsible for recording the clinical outcomes need to be explicit.

The intention is that those responsible for developing the services use the checklist, detailed in Table 1 with alternatives, to consider the right configuration of services for their own locality. For example, an initial decision will need to be made whether self-referrals are going to be accepted for the service.[11] Self-referral may improve access, but brief assessment is necessary to ensure suitability for computerised CBT.

The list of alternatives in Table 1 was generated through consultation with professionals who have used computerised CBT. Some of the options may work for particular sets of circumstances while others may be entirely inappropriate – and local providers will need to generate alternative ways of delivering computerised CBT.

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11 Self-referrals for cCBT were more compliant and improved more than did referrals for cCBT from mental health professionals (Mataix et al 2006, Compreh Psychiat, 2006, 47, 241-245). It was also found that a substantial number of self-referrals, including a disproportionately high number of NHS staff, would like to have access to cCBT without having to be referred by a clinician, and their severity is comparable to that of referrals by GPs. They improve appreciably with cCBT when offered a pathway to use NICE-approved cCBT confidentially without stigma (Marks et al 2003 & 2007). Furthermore, some PCTs have specifically asked for cCBT to be made available to NHS staff confidentially as part of the NHS Wellness program.

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It is important, therefore, to record the outcome of every patient that is taken on for the programmes. It is for the PCT to agree what other data may be appropriate to gather, again depending on local circumstances. Epidemiological data may be appropriate, previous intervention offered, previous mental health problems, concurrent physical health problems, whether or not the programme was chosen by the client/patient are all areas that you may consider as being important to record.

Demographic information and some outcome measures are included in the programs. This information can be readily accessed by the PCT.

Demand for service

A demand estimate tool has been developed which is intended to give PCTs a rough estimate of the likely demand for cCBT for any given population size. This tool is designed as an aid to PCTs and providers, and should be used in conjunction with other local indicators. A demand tool is also available on the NICE website – the costings and PCT coverage detailed in this tool are subject to review.

Cost benefits of cCBT

The cost benefit analysis undertaken by NICE assumed that 64% of CBT would be provided using a computer. This translated into significant cost savings of between £116 million and £136 million per annum in England compared to therapist face to face provision.

A total cost saving of £1,260,000 per 250,000 population over 2 years can thus be extrapolated. The demand estimate tool will model the effect of different population sizes and the proportion of people who chose to use cCBT.

Implementation issues for cCBT

cCBT needs to be considered in the same way as any other new development. In broadest terms the provision of the service will involve:

- understanding the demand and developing a service specification

- developing a contractual framework which includes the service specification

- undertaking a procurement of the services

- monitoring of the awarded contract against the service specification and other requirements.

There is no one model recommended for providing cCBT services that will fit all locations or circumstances and it will be up to PCTs to develop their own specification based on the needs and priorities of their local population and balanced against affordability.

This guidance is intended to initiate the thinking around the demand for such services and the development of a service specification for incorporation into a contractual framework to meet the local needs.

A clear project plan should be developed that involves the participation of local key stakeholders. The two companies that provide cCBT have experience of implementation and they both offer implementation support and training as part of the programme. There are also a large number of NHS, third sector, independent sector (IS) and other providers who have used the programmes. Many of them are willing to share their experiences.

The key service issues to be considered in developing a specification for cCBT services are detailed below. Only when these issues have been fully considered, as part of an option appraisal, will it be possible to develop an appropriate specification on which to procure these services.

Access: What types of venues do you see cCBT being delivered from? What advantages are there in extending opening times and using non-stigmatising settings or venues? What is the role of the third sector (charities, voluntary organisations etc) and independent sector in providing these venues?

Are you able to consider self-referral? How does this link with wider community initiatives such as *Pathways to Work*? Are there any specialist areas of delivery such as Prisons who would benefit from cCBT? Are any of your secondary care providers interested in utilising cCBT to help manage demand or reduce waiting lists? Do you have a telephone help-line service who may be able to support access for people?

What about workforce and/or Occupational Health Services, could they use cCBT? What about home usage? Where are the best places for people without their own transport to access?

Referral processes: How do you see people getting access to the program? Will it be direct from the GP and/or through a referral process? How will this be communicated? What protocols and procedures do you need to develop or can you amend existing ones to incorporate cCBT? How will appointments be arranged/managed? What is the role of Graduate Workers in the process? How and where is a risk assessment completed? What services/support do the suppliers offer to help with this?

Promoting cCBT: How will this be communicated to key stakeholders? How can you make people aware of cCBT as a choice of treatment? What is the role of Health Promotion/Public Health in this? How can the third sector or independent sector support this activity through their networks?

Facilities: *For NICE-approved cCBT which is not on the internet:*
Where can computers be best located to provide access to patients? How many hours a week can you deliver the service? How many venues would you want to have? What existing community facilities are there? What role has the third sector or local authority got in supporting this? What about using libraries and other community venues? What hardware do you need? Have you considered multiple computers in one room? How will the sites be supported by existing workers?

For NICE-approved cCBT which is available 24/7 on the internet: Patients access this at home or in libraries and elsewhere.

Technical support: What services do the companies offer? How does this fit with your local IT services? Who will be the lead contact from your IT team to help with implementation?

Participant support: Who will do this? How will existing workers be utilised to support cCBT? What do the companies provide to help with this? What training do participants need to complete the program? Is there the need to 'chase up' non-attendees? How do you do this for other treatments? Can it be incorporated in existing systems? How will you manage any emergency issues that arise?

Outcome measurement: What are you trying to achieve? How will it be measured? What existing key performance indicators are in place? How will you benchmark cCBT against similar treatment options? How does cCBT fit into your annual audit plan/cycle? How will you collect the data? What roles have the companies in supporting this?

Appendix 1

TABLE 1 This table outlines implementation procedures separately for CD-ROM-based cCBT (left-hand column) and for web-based cCBT (right-hand columns). The column for web-based FearFighter™ was developed in partnership with PCTs using this web-based cCBT round the UK (e.g. an independent Scottish-Highlands study – Hayward et al 2007; Scottish CSO office May-June 2006 http://www.sehd.scot.nhs.uk/cso/Publications/ExecSumms/MayJune06/Peck.pdf).

Many of the important findings about implementation procedures can save money for the NHS and maximise the clinical efficacy of cCBT.

	CD ROM e.g. Beating the Blues	Web-based Beating the Blues online	Web-based FearFighter
1. Referral, assessment and Booking	**Referrals may be accepted from:** • The GP or other health professionals in primary or secondary care services, after undertaking an assessment • Employment advisors, education workers, prison services etc • Employers' occupational health service • Employers	As for CD ROM In addition user/patient self referral may be appropriate	**Referrals may be accepted from:** • The user/patient – self referral • The GP or other health professional in primary or secondary care services, after doing brief assessment by phone or face to face • Employment advisors, education workers, prison services, etc • Employers' occupational health service • Employers

Screening and assessment of the mental state, including risk assessment and suitability for cCBT

Those responsible for securing provision of the cCBT service should ensure that a mental health and risk assessment is conducted by a suitably trained professional before treatment is offered:

• Assessment of mental state (including an assessment of risk) should be conducted by the users GP and/or mental health professional involved in cCBT screening/assessment

• A brief screening assessment is recommended to ensure the programme meets the needs of individual user's and reduces the potential number of drop-outs.

• In specialised settings type of problem and motivation for CBT should be assessed by a psychologist

As for CD ROM but telephone helpline may be considered

Risk assessment and suitability for cCBT:

• The user's GP or other health professionals

• Telephone helpline

• Those responsible for securing provision and providing the cCBT service

Suitability for cCBT (type of problem, absence of suicidal plans, education about the process of and motivation for cCBT) also needs to be determined. This can be done by a valid and free self-completed Screening Questionnaire which saves clinicians much screening time (Gega et al, CBT, 2005, 34, 16-21)

Booking appointments alternatives are:

- It is clear who is responsible for the booking service
- The GP receptionist/administrator manages the booking process
- The librarian/employment service manages booking process
- An independent organisation manages process
- Booking is incorporated into the overall service provided by an intermediate therapy team (IAPT) programme

As for CD ROM but appointments are not necessary for people accessing at home

Booking of appointments:

- Often web-accessed cCBT is used 24/7 at home without appointments. Appointments are only needed for brief initial screening by phone or face to face and for review after 6 weeks of cCBT use (to check improvement) and at 12 weeks (by when most patients have completed). Very few patients choose to use web-based cCBT in surgeries.
- Depending on the site of use, the library service, employment service, primary-care mental health team, or GP receptionist/administrator manage the booking process
- An independent care provider manages the process
- A central cCBT patient-support service
- Booking is incorporated into the overall service provided by an intermediate therapy team (IAPT) programme

Location of service

Site of the service can be:

• Remote – Client/user given a password to use the programme at a convenient remote location, home, library, office etc

• The GP surgery – the PCT should consider whether there is there sufficient space in the premises for a patient to have private access to a computer at times convenient to both patient and practice

• The Psychological Therapies Service should consider whether there is sufficient space in the premises for a user/client to have private access to a computer at times convenient to both user/client and the therapy service. The service should also consider how many user/clients can the service support at any one time

• The PCT should consider whether the base of the community mental health team is more appropriate. and whether the stigma of attending would be too great

• PCTs should consider whether a library, employment centre, leisure centre or charity café is more appropriate

• Provision in the prison service should also be considered

• (Provision as part of Pathways to Work may be appropriate)

The program can be accessed flexibly in all locations appropriate for CD ROM but also including home use

People can do some sessions in a central location and some at home. This overcomes issues of shift work, out of hours access

Some locations (like the prison service) may require secure servers to ensure that there is no access to the web. Provision of an online service to people on remand would ensure that they are able to continue with the program despite changing locations

Site of password-protected web access can be:

• **remote non-stigmatising settings –**

Usually: Client/user accesses web-based cCBT 24/7 at home, or at a friend, library, office, leisure centre, charity café, etc (i.e. anywhere having internet access)

Often: (if on Incapacity Benefit), in a Job Centre Plus centre, or community sites with Learning Ambassadors or other supporters. Some counties offer people on IB and single parents free internet access to improve their chances of obtaining a job. This can include e-learning for job hunting, and also web-based cCBT. Web-based cCBT is particularly acceptable to IB claimants who may not see themselves as ill yet have severe fear of returning to work, which cCBT can help resolve

• **settings with more concern about stigma:**

Rarely: GP surgery, base for community mental health team or Psychological Therapies Service, if their premises have sufficient space to offer a patient private access to a computer at times convenient to both patient and staff. How many users can each service support at any one time?

Occasionally: in a prison

Whatever the location:

• Is it appropriate to have:

  • Multiple computers in one room, with headphones for users, is cost effective for resources, and more likely to have support available at all times

  • But, having multiple computers in one room may be thought to reduce privacy. The use of 5 – 6 computers in one room using headphones does not affect service acceptability. This requires a much larger room but, given the throughput, it need not be used 5 days a week

  • Alternatively instead of investing in multiple computers in one centre, investing in a number of single computers distributed at a variety of locations within the PCT area – again support issues need to be considered

  • Exceptionally provision of CD-ROMs so that the user/client can access the service at a location convenient to them, e.g. their own home. As support may be an issue, this should only be considered in exceptional circumstances

Provision of an online product is preferable to a CD ROM for home use

Effect of mode of access:

Web-accessed cCBT is used mainly 24/7 at home, or at libraries and elsewhere where computers and printers are already present and so make no further demands on machines or space or on staff to schedule access. (See also above)

Support for users of the programme

Training of supporters

Experience suggests that, both software and occasional psychological support should be provided. Support can be provided through three routes:

- Software support, by telephone, may be available for the provider of cCBT by the commercial supplier. Telephone psychological support can also be considered

- face to face psychological support and support in helping the user log on to the program

- email support – probably best for just technological support.

- Patients are monitored weekly by an individual progress report and a summary report when they have completed the programme

- It is recommended that users have access to one practitioner who is able to offer support throughout the duration of the programme

- Training about the programme is provided by the providers.

- The PCT needs to ensure that all GPs are made aware of the availability of cCBT and provided with information about which people should be referred

Face to face or telephone support should be considered. The programme reporting system allows support staff to determine whether people have completed their sessions on schedule and to judge progress via the weekly progress report

Phone or face to face support may be appropriate for people who fail to progress.

Structured support calls at pre-determined points can also be considered

The data – base allows interrogation of demographics and outcomes across the population of the PCT. This can be visited at any time for audit purposes

Brief screening of and psychological support for users of web-accessed cCBT can be done by phone or face to face by staff who may have had minimal clinical experience. Their 5-6 structured support calls or emails to or face-to-face contacts with patients should be scheduled in advance and take no longer than 5-10 mins each to a total of no more than an hour in all per patient over 3 months. The 5'-10' structured support contacts are best initiated at weeks 1, 2, 4, 6, 9 and 12

These timings can be adjusted to guide users when supporters see on their cCBT clinical-outcome and patient-monitoring system that the user has reached Steps 2 and 5 where brief help is most appreciated

Weekly monitoring of patients can be carried out by support workers using the clinical-outcome and patients progress monitoring system. This takes only one minute per patient. The same system provides clinical outcome data routinely for the PCT and, as it is one central database, could do so for the NHS as a whole

| | Training is provided as part of the software licence | **Training of supporters of web-based cCBT users:**

They have worked through the web cCBT program thoroughly as a pretend patient and then been briefly trained (2 half days) to ask for specific information and to answer frequently-asked questions

Training is also provided to clinical data administrators on how to use the cCBT clinical-outcome and patient monitoring system to extract information for audit, etc… |
| **Software support is usually provided by the software provider, as part of the support and upgrade package.**

PCTs need to consider how to provide IT support for computers and printers | | The software provider offers **technological support** to PCTs' supporters of cCBT users. This is now a minimal activity due to technological improvements. Support is provided by phone or email to PCT staff. |

Psychological support can be provided by the following: • Graduate mental health worker • Practice nurse • GP • Assistant psychologist • Care worker • Other mental health professionals (Administrators/receptionists can offer some support to ensure that users are set up correctly on the programme but not psychological support.)	As for CD ROM	**Psychological support can be provided by:** • Administrator/practice receptionist • Graduate mental health worker • Practice nurse • GP • Assistant psychologist • Care worker • Other health professionals • Central/regional NHS helpline staff
Level of Psychological Support • Support could be provided at the beginning and end of every session or • Support could be provided at the first and the last session, and should be considered at times which are known to have a high drop out rate e.g. session 4 or 5	As for CD ROM	**Level of Psychological Support** **See 'Brief screening of …'** 4 cells above

Appendix 2

MEMBERSHIP OF EXPERT REFERENCE GROUP

Dr Alan Cohen	GP and Primary Care Advisor to CSIP	Sainsbury's Centre for Mental Health
Matt Fossey	Psychological Therapies Programme Manager	Care Services Improvement Partnership/Department of Health
James Seward	Choice and Access Programme Director	Care Services Improvement Partnership/Department of Health
Dr Fiona Ford	GP and Senior Lecturer	University of Central Lancashire
Dr Katrina Lake	IAPT Programme Manager	CSIP South East Development Centre
Dr Robert Alexander	Head of RDI	Commercial Directorate – Department of Health
Pippa Graham	Programme Assistant	Commercial Directorate – Department of Health
Darren Bickerstaffe	South Yorkshire Condition Management Programme Manager	Barnsley PCT
Helen Hardy	Primary Care Mental Health and Psychological Therapies Commissioning Manager	Bedfordshire PCT
Dr Neelham Dosanjh	Head of Counselling and Psychology	Newham PCT
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This guidance was written with the cooperation and assistance of:

SD Solutions Ltd
Ultrasis Plc

Glossary

BABCP	British Association for Behavioural and Cognitive Psychotherapies
CBT	Cognitive Behavioural Therapy
cCBT	Computerised Cognitive Behavioural Therapy
DH	Department of Health
DSM	Diagnostic and Statistical Manuel
IAPT	Improving Access to Psychological Therapies
IB	Incapacity Benefit
ICD	International Classification of Diseases
NICE	National Institute for Health and Clinical Excellence
PCT	Primary Care Trust
PD	Panic Disorder
PHQ	Patient Health Questionnaire
QOF	Quality and Outcomes Framework
WHO	World Health Organisation

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