

Delivering interventions for anxiety and depression in communities ... via health services

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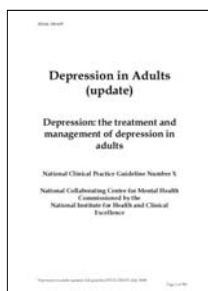
Overview

- Services: challenges of capacity
- It's difficult to introduce new ways of working into services
- Practitioner attitudes have an impact
- Infrastructure and IT policies are important too
- Make it essential - Make it happen - Make it stick

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National Health Service in the UK

- NHS- services
- National treatment guidelines



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Local delivery

- National guidelines often have mixed impact
- Local choices
- Issues of implementation (costs etc)
- Training/supervision
- Patient flow through services – redesign

- It takes time to redesign – and requires certain skills

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Drivers for change

- Making it essential
- Making it happen
- Making it stick

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**If the evidence is so good,
why doesn't anyone use
them?**

G E Whitfield
C J Williams

Behavioral and Cognitive Psychotherapy, 2006, 32, 57-65
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Clinical Section

IF THE EVIDENCE IS SO GOOD – WHY DOESN'T ANYONE USE THEM? A NATIONAL SURVEY OF THE USE OF COMPUTERIZED COGNITIVE BEHAVIOUR THERAPY

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Abstract. Computerized Self-help (CSH) has recently been the subject of a NICE (National Institute of Clinical Excellence) review. This increase in interest is also reflected in the increase in advertising for CSH programmes. We report a national survey of a random sample of 500 therapists accredited with the British Association for Behavioural and Cognitive Psychotherapies, which is the lead organization for CBT in the UK. A total of 129 therapists responded (65.8%). A surprisingly small number of CBT therapists were using CSH (12 or 2.6%) and only 5 or 1% were using it as an alternative to patient-therapist contact. Despite this, over 90% of the responding therapists had not studied nor used CSH in the future, but the majority of these would use it to supplement rather than as an alternative to individual face-to-face therapy. The need to have more robust computerized self-help and the need for training in therapy using this modality were seen as the main factors that would have to change to allow the therapists to use CSH. Knowledge of and ability to use computers did not appear to be an important factor as most therapists in this sample used computers on a regular basis. Most therapists were not aware of evidence of the effectiveness of CSH but the minority who did feel able to express views stated that CSH would be less effective than individual face-to-face therapy and would be less client satisfaction.

Keywords: Self-help, survey, computers, treatment, cognitive behaviour therapy, attitudes, clinical practice.

Introduction

Cognitive behaviour therapy (CBT) has a strong evidence base supporting its effectiveness in a range of common mental health disorders (Doh, 2001). Despite this, access to this treatment is often limited. There are currently just under 800 CBT practitioners who are accredited by the lead organization for CBT in the United Kingdom – the British Association for Behavioural and Cognitive Psychotherapies (www.babcp.com). It has been argued that most CBT is currently

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Sample

- Randomised sample of 500 therapists accredited with BABCP (www.babcp.com).
- Most expert available group of UK-based CBT practitioners.
- Drawn from full spectrum of mental health professions.

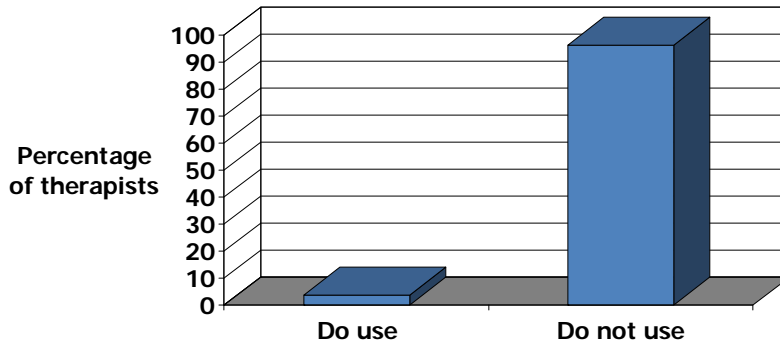
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Results

- 336 questionnaires returned.
- 329 completed (65.8%).
- 7 blank – (2 working abroad, 2 no longer working, 2 not at this address, & 1 did “not feel confident enough about the subject to complete the questionnaire”)

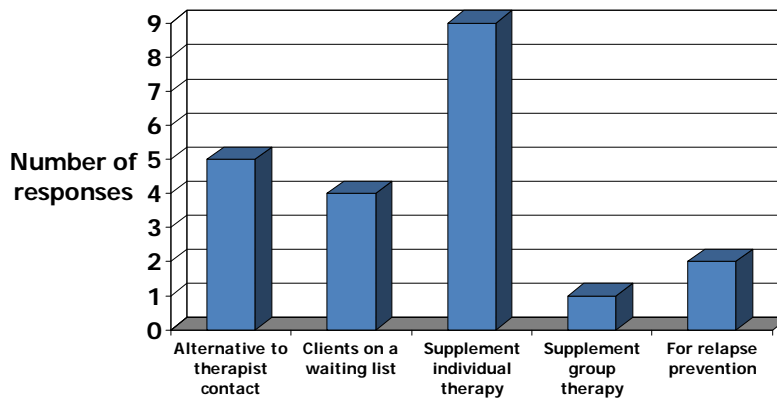
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Proportion of therapists who currently use computerised self-help materials (n=323)



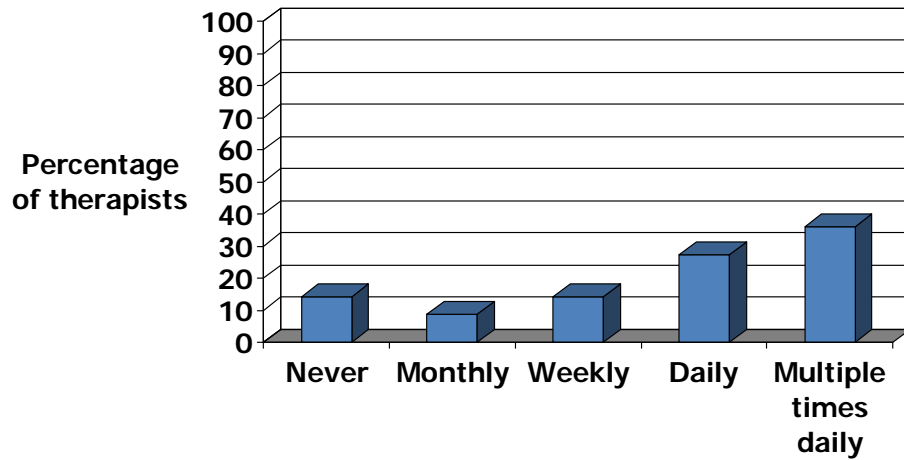
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“In which of the following situations do you use computerised self-help materials at the moment?” (n=12)



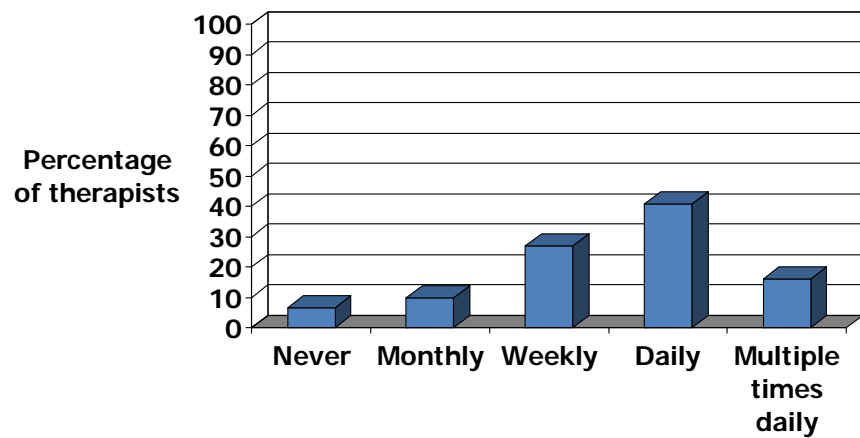
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“How often do you presently use a computer in your workplace” (n=326)



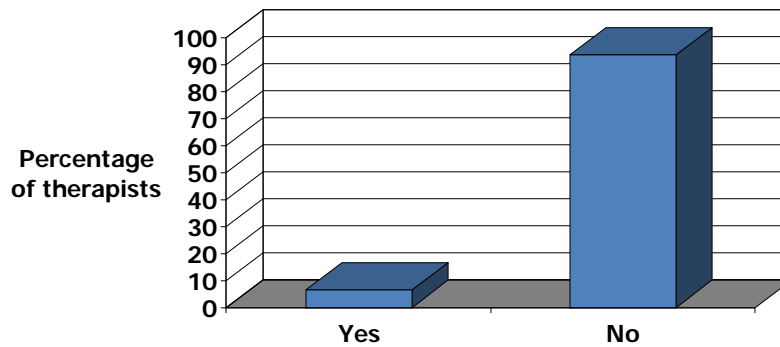
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“How often do you presently use a computer outside of your workplace” (n=324)



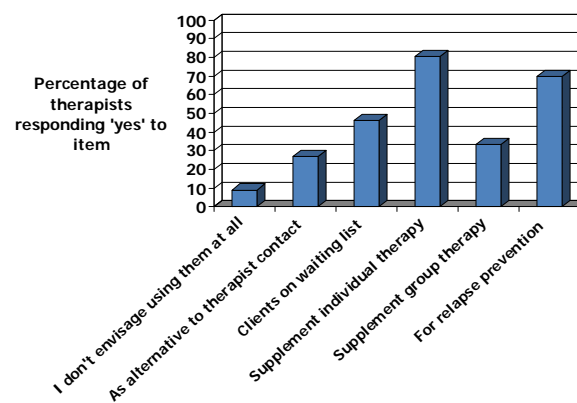
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“Have you had training in the use of computerised self-help materials for clients” (n=326)



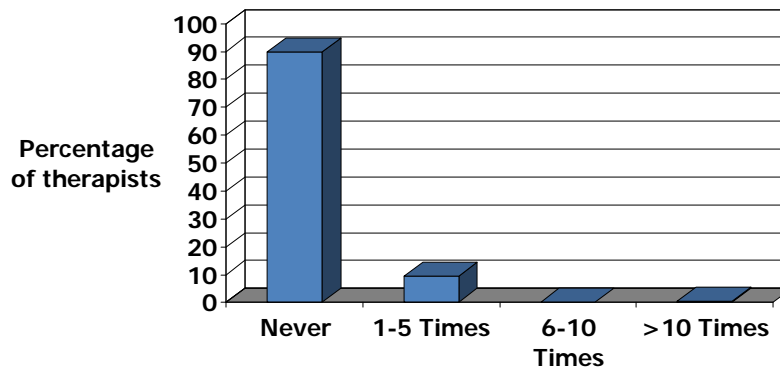
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“In which of the following situations do you envisage using computerised self-help materials in the future?” (n=316 or 317 for each item)



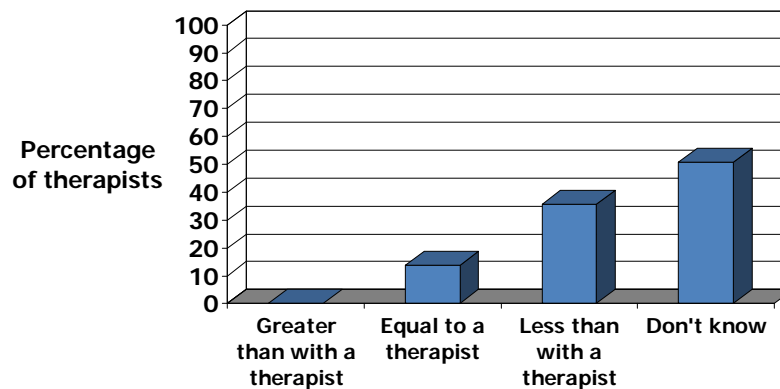
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**“How often have patients asked you for information on computer-based self-help treatments in the last six months?”
(n=326)**



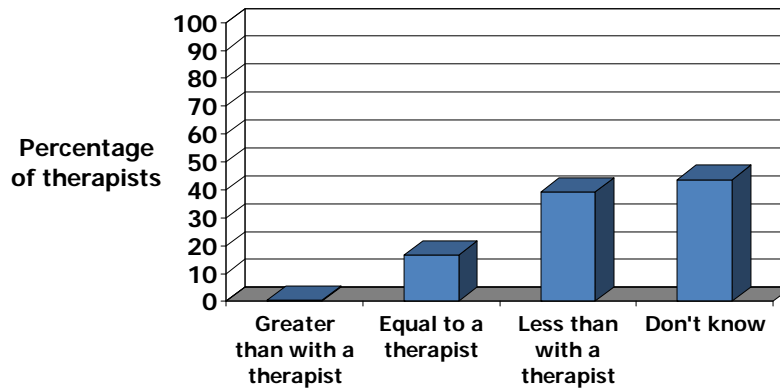
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“How would you rate computerised self-help materials on overall effectiveness in comparison to treatment with a therapist using a similar approach (e.g. cognitive/behavioural) (n=312)



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“How would you rate computerised self-help materials in terms of client satisfaction in comparison to treatment with a therapist using a similar approach (e.g. cognitive/behavioural) (n=316)



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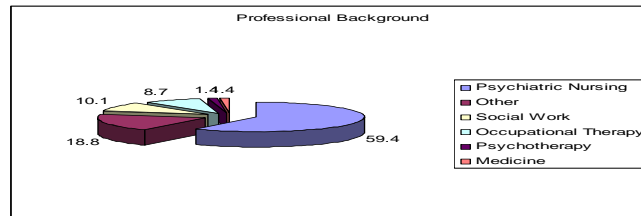
SPIRIT: A course in low intensity high capacity working

Sally McVicar, Susan Monks, Eileen Riddoch, & Chris Williams



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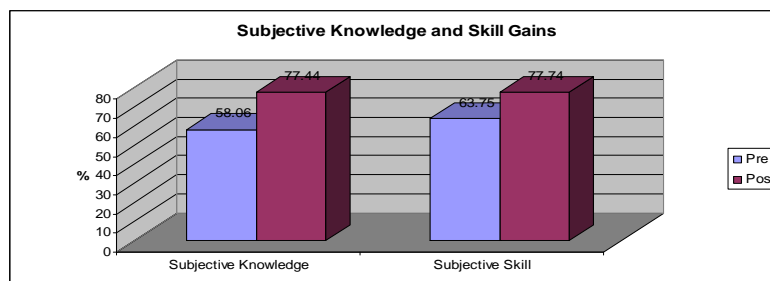
Demographics



- 71 individuals started training and 66 completed.
- Majority of trainees from a nursing background, however, more support workers and health improvement officers than in previous rounds.
- 46 recorded working in the community, 16 stated they worked in an inpatient environment, 1 in primary care and 1 ticked 'other'.
- 61 trainees described their current level of CBT expertise as basic with 8 describing their expertise to be of an intermediate level.
- Trainees from all four groups have been qualified for a range of 1 to 31 years, with a mean of 11.7 years.

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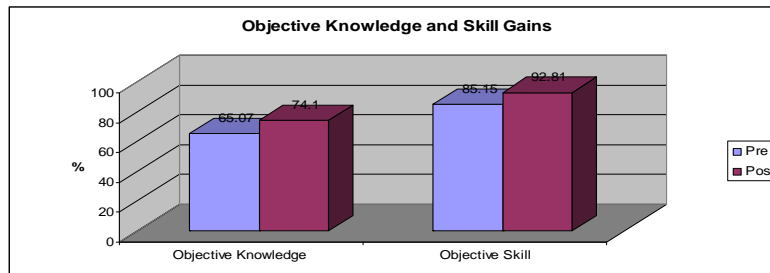
Subjective Knowledge and Skill Gains



- The above graphs shows significant gains in both subjective knowledge (68%-77%) and skill (53%-77%) following course completion.
- $P < 0.001$ in both cases

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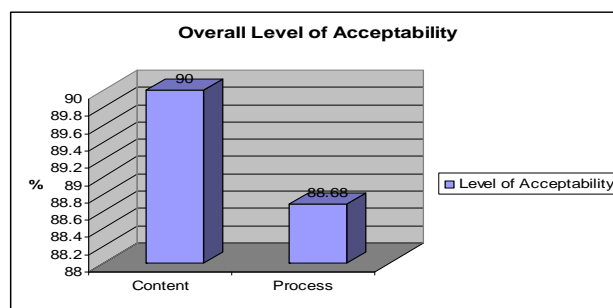
Objective Knowledge and Skill Gains



- $P < 0.001$ in both cases

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Overall Acceptability



- Overall acceptability of content was rated at 90.0% and process at 88.7%.

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Models of self-help / CBT resources



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Infrastructure Issues

Kenner et al. BMC Medical Informatics and Decision Making 2013, 13:152
http://www.biomedcentral.com/10.1186/12918-013-0152-2

RESEARCH ARTICLE Open Access

A national survey of health service infrastructure and policy impacts on access to computerised CBT in Scotland

David Kenner*, Claire-Anne McClay[†] and Christopher Williams[‡]

Abstract
Background: NICE recommends computerised cognitive behavioural therapy (cCBT) for the treatment of several mental health problems such as anxiety and depression. cCBT may be one way that services can reduce waiting lists and improve capacity and efficiency. However, there is some doubt about the extent to which the National Health Service (NHS) in the UK is embracing this new health technology in practice. This study aimed to investigate Scottish health service infrastructure and policies that promote or impede the implementation of cCBT in the NHS.
Methods: A telephone survey of head IT staff at all health board areas across Scotland to systematically enquire about the ability of local IT infrastructure and IT policies to support delivery of cCBT.
Results: Overall, most of the health boards possess the required software to use cCBT programmes. However, the majority of NHS health boards reported that they lack dedicated computers for patient use, hence access to cCBT at local sites is limited. Additionally, local policy in the majority of boards prevents staff from routinely contacting patients via email, Skype or instant messenger, making the delivery of such eCBT support services difficult.
Conclusions: Conclusions: Overall most of the infrastructure is in place but is not utilised in ways that allow effective delivery. For cCBT to be successfully delivered within a patient support model, as recommended by national guidelines, dedicated patient computers should be provided to allow access to online interventions. Additionally, policy should allow staff to support patients in convenient ways such as via email or live chat. These measures would increase the likelihood of achieving Scottish health service targets to reduce waiting time for psychological therapies to 18 weeks.

Background
 The National Institute of Clinical Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) recommend guided self-help (GSH) and computerised cognitive behavioural therapy (cCBT) for the treatment of depression [1, anxiety [2] and bipolar services [3]. In Scotland, the SIGN guidelines are especially influential and again recommend routine use of cCBT for depression [4].
 The main benefit of cCBT is that it enables delivery of cognitive behavioural therapy (CBT) content in a convenient way that adheres to the CBT model, and is suited to use as part of a stepped care model. Stepped care is a flexible model of healthcare delivery in which patients can begin their treatment with a low intensity intervention, progressing only if needed, to more complex interventions. Patients who do not respond to low intensity interventions are referred to higher intensity services. This model is particularly suited to those with complex presentations and patients who 'step up' to longer (high intensity) specialist care to face therapy if improvements are not seen after a given time [5]. Delivering cCBT as part of a stepped care approach increases service capacity and provides an evidence-based intervention for those individuals with mild-to-moderate or severe depression. For example, who are otherwise best placed to receive access to specialist CBT [6].
 Patients can work through the computerised packages (online or on CD-ROM format) independently and receive minimal input from the clinician. Short support sessions can be for encouraging outcomes, especially for

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Open Access Research

BMI open A national survey of the infrastructure and IT policies required to deliver computerised cognitive behavioural therapy in the English NHS

Holly Andrews¹, David Kenner², Claire-Anne McClay³, Christopher Williams⁴

ABSTRACT
Objective: This study aimed to identify if patients have adequate access to Computerised Cognitive Behavioural Therapy (cCBT) programmes at all mental health trusts across England.
Design: The primary researcher contacted a targeted sample of information technology (IT) leads in each mental health trust in England to complete the survey.
Setting: Telephone, email and postal mail were used to contact an IT lead or nominated expert from each mental health trust.
Participants: 48 of the 161 IT experts from each mental health trust in England responded. The experts who were chosen had sufficient knowledge of the infrastructure, technology, policies and regulations to answer all survey questions.
Results: 75% of trusts provided computers for direct patient use, with computers at all except one trust meeting the specifications to access cCBT. However, 24% of trusts acknowledged that the number of computers provided was insufficient to provide a 100% service. 77% stated that the bandwidth available was adequate to provide access to cCBT sites, yet for many trusts, internet speed was identified as problematic and variable between locations. IT policies in only 50% of the trusts allowed National Health Service (NHS) staff to directly support patients in the computerised CBT content, which is the primary purpose of cCBT. Only 17% allowed support via instant messenger services.
Conclusions: Trust access to cCBT in England being mental health trusts is limited by the inadequate number of computers provided to patients, unsuitable bandwidth speed and inconsistent IT policies, which mental patients from requesting the support needed to maximise the success of this therapy. English NHS mental health trusts need to alter IT policy and resource allocation to reduce the waiting time for psychological resources required for patients seeking the evidence-based therapy.

INTRODUCTION
 There is an increasing need to improve access to psychological therapies for patients with mental health problems in the UK. Cognitive behavioural therapy (CBT), delivered to individuals in a structured manner, usually lasting 12-16 weeks, is known to be effective in the treatment of various conditions such as depression, anxiety and bipolar services.¹⁻³ However, this type of therapy is scarce in some areas and is delivered

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Methods

- **Design:** Survey of Information Technology (IT) leads in each mental health trust in England.
- **Setting:** Telephone, email and postal mail were used to contact an IT lead or nominated expert from each mental health trust.
- **Participants:** 48 out of the 56 IT experts



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Results

- 77% provided computers for direct patient use,
- Computers in all except one meet specifications to access cCBT.

- 24% insufficient to provide a trust-wide service.
- 71% stated that the bandwidth available was adequate
- For many trusts internet speed was identified as unpredictable and variable
- IT policies in only 56% of the trusts allowed NHS staff to directly email patients
- Only 37% allowed support via internet video calls
- Only 9% allowed support via instant messaging services.

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Questions

- Is it possible to deliver cCBT in routine services?
- ? A centralised resource?
- Equity and access is an issue
- IT issues and especially policy decisions can affect role out
- Practitioner attitudes vary
- Inconvenient truth: Many services express disappointment with cCBT

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So.... How do we make it essential?

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