

## Debate

# Service development report: an assistant psychologist's perspective on the use of computerised cognitive behavioural therapy in a GP practice in Barnet

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## ABSTRACT

Access to psychological therapies in primary care remains inadequate. Current research suggests that the delivery of cognitive behavioural therapy (CBT) via a computer interface (CCBT) may be of value in the management of anxiety and depressive disorders. The use of CCBT is a fairly recent development in the NHS and this paper reports on the

experiences of implementing such an innovative service in a general practitioner practice, using an interactive multimedia CBT programme, *Beating the Blues* (BTB).

**Keywords:** cognitive behavioural therapy, computer interface, psychological therapies

## Introduction

There is substantial evidence to support the effectiveness of therapist-led, face-to-face cognitive behavioural therapy (CBT) for the treatment of anxiety and depression, but the high demand for adult mental health services largely outweighs the limited access in the NHS.<sup>1,2</sup> The contributing factors to this problem include a shortage of qualified therapists, cost, waiting times, and patient reluctance to enter therapy. These problems unfortunately can be seen to permeate through the system, with the long waiting times for specialised services forcing people with mental health problems to seek and access help at the primary care level, consequently stretching these resources to their limits. It is estimated that 20% or more of patients consulting general practitioners (GPs) have, as their principal medical condition, anxiety, depression or mixed anxiety and depression. The use of different packages of CBT via a computer interface

(computerised cognitive behavioural therapy – CCBT) is increasingly being explored as a means of narrowing this demand/resource gap and has illustrated its effectiveness, however preliminary the research.<sup>3,4</sup> The National Institute for Clinical Excellence (NICE) recently published guidelines on the use of CCBT and one of their recommendations highlighted the need for more independent pilot monitoring projects.<sup>5</sup>

## What is *Beating the Blues*?

Ultrasit UK Ltd developed *Beating the Blues* (BTB) in association with Psychology at Work Ltd, an initiative of the Institute of Psychiatry.<sup>6</sup> BTB is a computerised package designed to deliver CBT for anxiety and depression in primary care and other healthcare settings. The programme uses multimedia techniques and comprises a 15-minute introductory video and eight one-hour

sessions. Each session integrates both cognitive and behavioural techniques, which are designed to promote more helpful thinking styles and accompanying behavioural repertoires. Homework tasks are set at the end of each session for the client to complete during the week, and a progress report, including whether the client has expressed any suicidal intent, is printed out. This is shown to the clinical assistant/facilitator at the end of the session, but is retained by the client.

## The pilot CCBT service

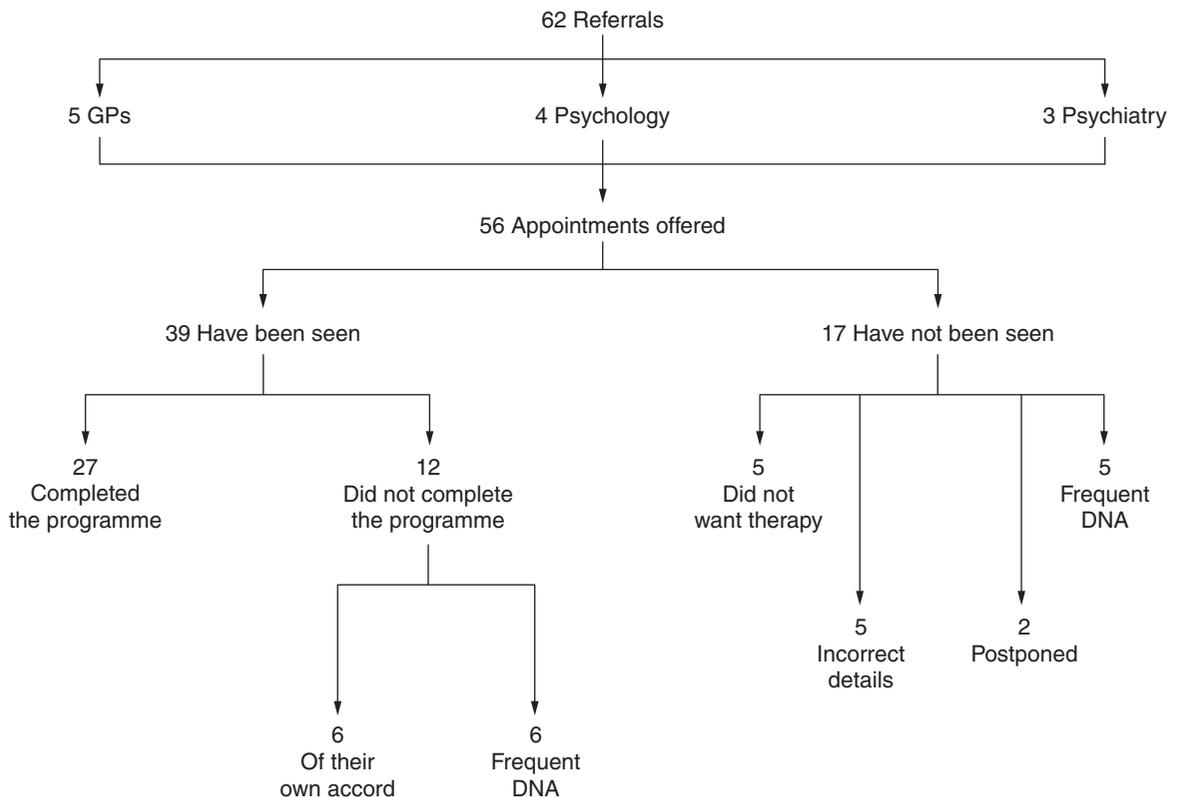
The Clinical Psychology Department in Barnet and the Barnet Primary Care Trust (PCT) decided to launch a joint project with the Torrington Speedwell Practice in North Finchley, evaluating the implementation and running of a CCBT service, using the BTB package.

The first three months were spent setting up the service. This developmental stage consisted of a number of phases. These included liaising with the surgery's practice manager in order to co-ordinate the timetable for the clinic, and organising room availability in the surgery. Frequent contact was made with research psychologists and the support team from Ultrasis to maintain their clinical standards

and for any technical support. Advertising saw the preparation of the literature for prospective users and referrers and carrying out presentations to GP practices in the area. Measures of change and screening procedures were identified and clinical and management supervision arrangements were also established.

Clients were given The Brief Symptom Inventory and the patient questionnaire (the department's in-house evaluation tool), which provides the patient's subjective opinion regarding the severity of their problems.<sup>7</sup> Both measures were given before and after therapy. Each week the clients were also asked by the BTB programme to rate their levels of anxiety and depression along an eight-point scale. Finally, during the post-therapy assessment, clients were asked to give their views on the service and the programme.

The development stage took longer than anticipated. After overcoming the various start-up problems such as room availability and a lack of GP response, the BTB clinic continued to run successfully. From a total of nine GP practices regularly referring clients, 56 appointments were offered in the period from October 2002 to July 2003. From this total, 39 (69.6%) clients started the programme, but 17 (30.4%), for various reasons, never took up the appointment. At the end of this period, 27 out of 39 (69.2%) clients completed the eight-week programme (see Figure 1 for more detail).



DNA: did not attend

**Figure 1** Flowchart showing clients' outcomes after the initial referral

## Discussion: a personal view

The experience of running this service has generated a number of findings. From an organisational perspective, it is a high-maintenance service to run. It needs a clearly defined supportive infrastructure, including reception, room availability, and the co-ordination of booking appointments on an eight-week cycle. It requires careful induction of new patients, post-therapy assessment, real-time trouble-shooting (clinical and IT), risk assessment, clinical supervision and management support.

Within this framework, several issues arose merely through running the service from within a primary care setting. Firstly there was the constant need for administrative and communicative efficiency between the clinical assistant, practice manager and surgery staff. This is vital due to the constantly busy environment of a GP practice and other factors, such as staff rotation and room availability. Separate rooms are necessary for the client and the clinical assistant during each session, a requirement that can also be difficult in a busy surgery.

Referrers also needed to have strict referral guidelines to follow. It became apparent that on a number of occasions clients arrived for their first session oblivious to the nature of the therapy. Referrers were then repeatedly made aware of the importance of informing clients that it is a computerised therapy programme and that human contact is minimal. It is very much a self-help programme, which requires motivation and management from the client.

The nature, quantity and quality of facilitator support varied from client to client. However, the majority of clients required some human clinical assistance and interaction. This varied in format; from clients requiring explanations relating to the programme, carrying out risk assessments and answering questions that had arisen from their homework tasks, to general conversations regarding the client's well-being. Consequently, the clinical helper would have to be adequately trained in CBT. Taking the above into consideration, together with the high level of organisation needed to run such a service, administration and clerical staff would not be able to manage this type of service, especially if operating from a busy GP practice.

By way of providing more detail, and a balanced view, the following positive and negative aspects of running a CCBT service in a GP practice are discussed simultaneously.

### Plus points

It offers effective, efficient and immediate access to CBT. Such an approach could reduce the number of

repeat primary care consultations and the demand made on more specialised services. This could have the added advantage of freeing up secondary care resources where those practitioners could be directed to patients with more complex or severe difficulties. It should be noted though, that there is only preliminary evidence to support this, and further investigation is therefore needed.

It offers an effective and reliable form of CBT, where the client can take a leading role in the management of his/her problems. Accessing therapy in a primary care environment, could for some people, eliminate the stigma attached when attending a mental health service. Such a service could then increase treatment flexibility for individuals who do not want or who are not suitable for drug therapy, and there may be some individuals who do not wish to interact with a therapist.

The post-therapy assessments overall revealed an encouraging response to the BTB programme, with the majority of clients responding positively to its design and delivery. On asking clients about the setting for the service, the majority said they would have still attended the programme if it were run from a mental health department. The summary sheets printed out at the end of each session were repeatedly commented upon; clients found these extremely helpful and productive, using them to compile their own 'self-help manual' to refer to at a later date.

For the Assistant Psychologist, and the service, efficient use of the time in between starting and finishing individual client-sessions was ensured by her using the time to work on BTB admin, or to work on other projects. As well as responding to needs of the client during therapy, the assistant psychologist was able to complete a number of different projects and audits while waiting for clients to complete their sessions. A practice-based nurse could be similarly engaged.

### Minus points

As with all types of psychotherapy treatment, it was found that some clients did not like the BTB programme and subsequently discharged themselves from it. Some clients found the programme quite 'patronising' and 'condescending', finding the automatic responses made by the computer particularly 'offensive' and 'insincere'. However, these comments were few and far between, with the majority of clients responding well to the overall programme delivery.

The results of the economic analysis of CCBT using BTB indicated that compared to GP treatment as usual, BTB is a cost-effective strategy for treating patients with anxiety and depression.<sup>5</sup> It is worth reading the NICE review as it gives a detailed breakdown of the costs. It shows clearly that in order to provide this service, you have to employ a practice-based nurse or

assistant psychologist to operate the system, which costs around £15 000 a year. In addition there is a licence cost, currently about £10 000 a year per screen.

Running the service from a busy GP practice meant that one had to adhere to the goings-on of a busy GP surgery, for instance room availability was a recurring problem, and so the flexibility of the service's timetable was somewhat restricted.

## Conclusion

Through our own experience of implementing and running this service, it can be concluded that BTB, when used in conjunction with help from a clinical assistant may be useful in the management of mild-to-moderate levels of anxiety and depression. People with more complex and severe difficulties may not be as responsive to such first-line treatments and would require more therapist involvement.

CCBT packages help to promote Standards 2 and 3 of The National Service Framework.<sup>8</sup> Standards 2 and 3 state that 'any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments and be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care'.

We found that a CCBT service could be set up successfully within a primary care setting, where access to CBT was readily available in a supportive environment. While running the service from a primary care setting, it is important, however, to retain supportive links with secondary services for on-line clinical supervision, risk assessment and referral needs. In addition, CCBT can be seen as a complementary service to GP consultations and/or the immediate referral to more specialised services.

## Future developments

CCBT could work well as part of a 'stepped-care' model of treatment delivery, extending its accessibility, for instance as a first-line resource for clients currently on a waiting list for therapist-led therapy. At least two clients adopted this ideology; one used it whilst on a waiting list for therapist-led CBT and the other used it as part of a stepwise approach to therapist-led therapy.

CCBT can reduce therapist time, which is useful where access to therapist-led CBT is limited. The most efficient set-up would be where more than one programme is being run from the same site and so one

therapist can manage multiple users at the same time. This, however, calls for a major investment in multiple screens, and a clinic manager, as well as ensuring that a solid infrastructure is set up and managed.

A more detailed investigation is needed into the effect CCBT services have on the number of repeat GP consultations the patient receives after starting this form of therapy, and whether it provides a complementary service to GPs' workload. It would also be beneficial to look at the referral activity from primary care to secondary care, specifically the effect, if any, on the waiting times for therapist-led CBT.

Finally, long-term provision of CCBT in the NHS needs careful consideration and skilled monitoring of potentially at-risk patients. It is not a quick-fix elixir to zero waiting times for all.

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## CONFLICTS OF INTEREST

None.

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