Scotland: cCBT in Scotland

Part 1: General Information

Publication on EIP on AHA Portal	Yes
Copyright	No
Verification of the Good Practice	Yes
Evaluation of the Good Practice	No
Type of the Good Practice	Good practice

Part 2: Description of the Good Practice

Name of the Good Practice	cCBT in Scotland
Short name (Acronym)	Not applicable
URL of the Good Practice	Not applicable
Geographical scope	National level
Country	Scotland
Region(s) involved	14 Health Boards in Scotland: NHS Greater Glasgow and Clyde NHS Borders NHS Dumfries & Galloway NHS Highland NHS Orkney NHS Western Isles NHS Ayrshire & Arran NHS Grampian NHS Fife NHS Shetland NHS Lanarkshire NHS Forth Valley NHS Tayside
Status of the Good Practice	On-going
Stakeholders involved	• Specialised physicians • General practitioners • Private companies • Nurses • Academia • National public authority • WHO • Regional public authorities Local public authorities
Size of population covered	10,000 - 99,999
Targeted audience	<18, 18-49, 50-64, 65-79, 80+

Summary of the Good Practice

The practice covers mental health in particular the treatment of those individuals suffering from depression and anxiety. The aim of the practice is to offer evidence-based treatment on a large scale to all those patients deemed suitable for a computerised treatment by a competent clinical member of staff. The treatment is delivered in the individual's home and who are directly responsible for the management of their treatment. The computerised therapy (cCBT) is co-ordinated and monitored locally by cCBT Services based in each of the specific territorial Health Boards. The method of implementation and the service model are key to the successful establishment of the cCBT services and are adapted locally from a standardised model of implementation development and tested over many years. The cCBT services are integrated into the local psychology therapy stepped or matched care clinical service models and offered as a mainstreamed treatment option. The implementation, service development, clinical governance and service usage is overseen by a national team who take responsibility for the overall success of the cCBT practice in Scotland. Within this national team there is expertise

Key words: Mental health, efficient, effective, innovative, service

Good practice being part of the larger programme

Yes.

MasterMind: MasterMind is a European project that will define the key barriers and facilitators when implementing cCBT. The project in Scotland was the starting point for a wider implementation now called cCBT TEC which encompasses the implementation of sustained cCBT services in all territorial Health Boards in Scotland.

Challenges / problems addressed by the good practice

The practice will primarily be used to provide patients greater access to psychological therapies. There is an ever- increasing demand for mental health treatment across a wide spectrum of severity and range of conditions. The provision of computerised CBT provides a cost effective, large-scale solution in the treatment of the most prevalent mental health conditions such as depression. The solution can be used by a range of clinicians across a number of specialities with over 22 different services now referring to cCBT in Scotland, this including GPs, psychologists and psychiatrists.

Importance of the challenges / problems before starting to implement good practice

The problem is considerable. Depression is the leading cause of disability worldwide and the demand for treatment is on the raise due largely to increasing life expectancy. Depression is highly prevalent and has a severely negative impact on mental wellbeing of the individuals, their quality of life and their social and work-related functioning both on the short and long-term. Depression is one of the most expensive diseases, with the

economic cost of depression doubling over the last ten years in many EU countries. Costs across the EU in 2010 were estimated at €136.3 billion and only a third of this cost is directly related to the treatment of the condition. The remaining two thirds related to indirect costs such as lost productivity or absenteeism from work. With the increase in demand more traditional styles of treatment such as face-to-face therapy are unable to keep up with the demand for treatment leading to long waiting times.
Environment before the good practice was implemented There was limited options for GPs at the point of diagnosis as the majority of patients that will use cCBT will not be suitable for face-to-face psychology services as they will be suffering from moderate symptoms. The options available to GPs would be medication namely anti-depressants or recommendations to self-help materials online or in local libraries. The practice has already indicated that it can and is used as a first treatment for depression with 23% of patients having had no previous treatment before commencing with cCBT.
Key innovative elements of the good practice and how the good practice improved situation compared to previous practice cCBT in Scotland is still in development and is currently available in 6 of its 14 Health Boards, 44% of the population, the remaining population will be provided access in 2017. At this point in the implementation process the cCBT services provides access to evidence based psychological treatment to over 7,100 patients per year at a cost that would be equal to employing approximate 4 clinical psychologists with a maximum potential caseload of 400 patients per year. cCBT is completed in patients home and delivered online via their web browser. The patient manages their treatment but is monitored centrally and patients when required can access support.

Part 3: Transferability of the Good Practice

Cost-effectiveness of the good practice (including all kind of costs and outcomes such as better health, quality of life or other resources)	Lower costs, equal outcomes
Resources required for the deployment of the good practice (personnel, equipment, facilities, ICT and other resources required The treatment is completed either in the patient's home or at community locations such as libraries using existing equipment and technological infrastructure. The key cost is for a licence for the cCBT software, this is a nationally procured licence so the costs are reduced due to the economies of scale. The other resource requirements relate to the administration of the cCBT services in each of the 14 Health Boards and are determined by the size and expected activity of the local cCBT service. It is expected that approximately 19 administrators will be needed in total across all services in Scotland. In addition to the	

running costs there are implementations costs that relate to staffing a national implementation team. This team is made up of two full time members of staff who work with each of the territorial boards during the implementation process.	
Total budget of the Good Practice	€100.00 - €499,999
Source of funding	National funding
The main actions that have to be done to deploy the Good Practice There are many steps taken during the deployment process. The first of these is to engage with territorial Health Boards to; set-up local clinical governance and management structures, recruit service administrator, train local staff in cCBT program and service administration, set-up all administration procedures and adapt service model to local needs, set-up referral routes and integrate service into local psychology stepped/matched care models. After this stage, the next step in the process is the engagement with referrer groups and market services within local areas. This will account for the majority of time taken to implement the service, approximately two thirds of the allocated time and will ultimately dictate the success and scale of the service in each of the areas. The final stage is to ensure that mainstreamed, sustained funding is found within the territorial boards for the running costs of the service.	
Issues during the implementation of the Good Practice There have been 2 significant difficulties. The first relates to technical issues caused by the age of the cCBT product that is currently the program of choice in Scotland. The second and more significant issue relates to the engagement of clinical staff and the generation of referrals. When using technology in a treatment setting there is a need to overcome negative attitudes and distrust that may be present within clinical settings. This was overcome through an appropriate marketing strategy and the presentation of the evidence of the successful clinical outcomes of treatment and the benefit of cCBT services.	
Additional resources required to scale up Good Practice No.	
Basis to support sustainability of the Good Practice This practice fulfils a need within the health care system in Scotland. The scale of deployment and usage combined with the demand of the services for depression, the cost and clinical effectiveness of the services and the longer- term potential impact supports the argument for sustained services.	
Evidence to observe the Good Practice A practice report, video or digital media, a visit to implementation site.	

Part 4: Viability assessment of the Good Practice

Time needed to deploy the Good Practice Between one year and three years. To prepare for the implementation an understanding is developed that focuses on the structures of the psychology service in each of the individual Health Board areas. In addition evidence of the effectiveness of this type of treatment is identified. Those employed at the national levels are identified from a pool of individuals with genuine expertise in the areas of mental health, technology and service implementation. During the implementation process training materials and marketing materials must be developed. Finally some form of central monitoring of the service must be set-up.
Investment per citizens / patient / client in terms of financial resources Between €100 – €1.000 per targeted citizen / patient. The cost per patients has been calculated by dividing the total running costs of the service including staffing and the cost of the national cCBT software licence by the number of patients accessing the service, within a 12-month period. This method of calculating the costs per patient is used by other mental health and clinical psychology services such as face-to-face, therefore making it directly comparable between the more traditional services and cCBT.
Evidence behind the Good Practice Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the Good Practice. The evidence for the clinical intervention i.e. cCBT has been identified from within key clinical publications. Clinical publications have also been written based on the results of the cCBT practice in Scotland through the MasterMind project. Evidence of the success of the service model and implementation process is gathered during deployment and from routine practice. This evidence includes referral rates and patterns, engagement in treatment and completion rates, clinical outcome data and patient satisfaction data. Evidence from the services is collated nationally and analysed by those in the national implementation team with the clinical and implementation expertise. All results are shared between the national team and the territorial boards and are used to shape service improvement and marketing activities.
Maturity of the Good Practice There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use. The first cCBT services where established in Scotland between 2005 and 2007. In 2014 an additional 4 service were developed. All services have been running at capacity and are

fully integrated into the mainstream service models. The rollout of cCBT will be completed in 2017 with the establishment service in the 8 remaining territorial Health Boards.
Estimated time of impact of the Good Practice Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began.
Impact observed Better health (societal) and better quality of life The impact of the services is focused on two areas, the impact on the individual and the wider impact on society and the health care systems. The impact on the individual occurs during and after treatment, these are identified through clinical outcome measures embedded in the cCBT programme which are monitored and reported on a month basis. The wider impact will take longer to realise and is dependent on the final scale and usage of cCBT in Scotland. The wider impact on society can be monitored nationally through analysis of prescribing rates, employment status and absenteeism rates.
Transferability of the Good Practice The innovative practice has been transferred in other locations or regions or national scale in the same country. The process of cCBT implementation is well formed, evidenced and documented. The service model would be the same regardless of the environment in which it is deployed with only minor changes to enable local objectives are met. The fundamental aspects of the implementation such as the marketing, clinical needs and treatment can be readily transferred from one location/region to another. The expertise developed at a regional and national level is made available during the implementation process and lesson learnt are integrated into service procedures and processes prior or during the point of implementation.

Part 5: Your organisation

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