

Adoption report: MT588 Early Value Assessment: Digitally enabled therapies for adults with Depression and MT589 Early Value Assessment: Digitally enabled therapies for adults with anxiety disorders

Summary

Adoption levers identified by contributors

- May increase treatments options.
- Could lead to an increase in practitioner capacity.
- May be a successful treatment option and lead to improved outcomes.
- Greater accessibility for those with long term conditions, busy work/life schedules and those where being open about mental health conditions may be particularly challenging.

Adoption barriers identified by contributors

- Training: time required to attend 1–2-day training sessions and then to gain a thorough understanding of the digital content.
- Cost may be a barrier. Particularly if there isn't a strong evidence base showing that use leads to good outcomes and savings elsewhere e.g., therapist capacity.
- Equity of access- This type of therapy may not be an option for all due to access to technology (e.g., smartphone or computer) and or technology literacy level.

1 Introduction

This adoption report has been developed to support both MT588 Early Value Assessment: Digitally enabled therapies for adults with Depression and MT589 Early Value Assessment: Digitally enabled therapies for adults with anxiety disorders. Although some technologies are being considered for either depression or anxiety disorders only, others are for both. We found that there was significant overlap between the adoption barriers and levers to using digitally enabled therapies for

adults experiencing depression and/or anxiety disorders. We highlight within the report if a barrier is specific to one condition or technology only.

Following the scoping workshop, the adoption team has collated information from healthcare professionals working within NHS organisations with experience of using some of the digitally enabled therapies considered within the scoping documents. All contributors apart from 1 had experience of using one of the therapies either as part of their service or a pilot. The contributors table in section 2 shows the split of contributors across the different technologies. It has been developed for the medical technologies advisory committee (MTAC). This report provides context from current practice and an insight into the potential levers and barriers to adoption and includes adoption considerations for the routine NHS use of the technologies. It does not represent the opinion of NICE or MTAC.

2 Contributors

Details of contributing individuals are listed in the below table.

Job title	Organisation	Current use	Technology	Anxiety/ Depression/ Both	Therapy stage
GP partner and Clinical Director of Primary Care Warwickshire	Grange Medical Centre and GP Federation in North Warwickshire	Free access as part of a pilot involving 7 GP practices	Deprexis	Depression	Prior to IAPT access
Lead Psychological Wellbeing Practitioner	Telford and Wrekin IAPT	Part of current service provision	Silvercloud	Both	Step 2
Primary Care Therapist	Cwm Taf Morgannwg University Health Board	Part of current service provision	Spring	Anxiety-PTSD	
Primary Care Therapist	Oxford Health NHS Foundation Trust	As part of research trial within IAPT service	iCT-PTSD	Anxiety- SAD	
Step 3 Lead / Cognitive Behavioural Therapist	Telford and Wrekin IAPT	No	Silvercloud	Both	Step 3
Senior Cognitive Behavioural Psychotherapist	Hywel Dda University Health Board	Part of current service provision	Spring	Anxiety-PTSD	
Primary Care Therapist	Cwm Taf Morgannwg University Health Board	Part of current service provision	Spring	Anxiety-PTSD	
Clinical lead of IAPT service & clinician	Hertfordshire Partnerships University NHS Foundation Trust	As part of research trial within IAPT service	iCT-PTSD	Anxiety-PTSD	Step 3
Head of commissioning, mental health and learning disabilities & Therapist	Isle of Wight CCG	Part of current service provision	Silvercloud (previously) & Minddistrict	Both	Step 2

Clinical Services Director	Trent PTS, provides services for regional IAPT	Part of current service provision	Iona Mind Minddistrict SilverCloud	Both	
Clinical lead of IAPT service & clinician	Hertfordshire Partnerships University NHS Foundation Trust	As part of research trial within IAPT service	iCT-PTSD	Anxiety-PTSD	Step 3
GP (non – user)	Birmingham Medical School	N/A		Both	N/A

3 Use of digitally enabled therapies in practice

All the contributors to this report who are currently using digitally enabled technology are doing so following an initial assessment. This assessment identifies the mental health condition to be treated and assesses if the person is likely to be suitable for guided treatment with digitally enabled therapy. Assessment of risk also happens here in addition to throughout treatment. Risk assessment is embedded within all the technologies the contributors to this report are using.

The contributor currently using Iona Mind, has set up a minimum contact pathway. This involves training their psychological wellbeing practitioners (PWP) to complete short follow up calls with people using the app and only set up longer virtual or face to face (traditional) appointments for those who are not demonstrating an improvement.

One of the contributors using Spring has set up a separate waiting list for those assessed as appropriate for treatment assisted with this technology. This is much shorter than the waiting list for traditional face to face CBT.

One contributor is currently offering Deprexis as part of a pilot within primary care. They are offering this to people prior to accessing IAPT (following supported decision making, an assessment and completion of PHQ9) due to long waiting lists. This contributor provides follow up phone calls/appointments with people as they work

through and after completion of the 90-day programme. If, following the assessment, people decide they would prefer face-to-face therapy via IAPT, this service initiates Deprexis for them to use while they await their IAPT appointments. Once IAPT has commenced, Deprexis is stopped.

Some contributors have simply integrated the use of digital therapy into the IAPT service as is. No one reported that offering this service has required large service or care pathway redesign.

4 Reported benefits

The potential benefits of adopting digitally enabled therapies, as reported to the adoption team by the healthcare professionals using the technologies are:

- May increase treatment options.
- Could reduce waiting times and allow more people to access treatment due to greater practitioner capacity.
- Could allow people to take ownership of their own care.
- Should lead to greater flexibility for users to access therapy at a time that suits their needs/lifestyle.
- May help with confidentiality as the user can pick a time when other people may not overhear or be able to see any content they add to the digital therapy.
- Continued support post guided therapy.
- Use may lead to improved outcomes and successful treatment.
- Digital enabled therapy may include features which are not possible to achieve through standard therapy, e.g., normalisation of symptoms through insight into other people's journeys.

5 Insights from the NHS

Commissioning

One contributor discussed the fact that it is challenging to pull together a business case for a technology that is not yet proven to work and won't work for all. Different

digital therapies are likely to work for different people and so an estimate of how many of each to be purchased is required. This is difficult to forecast.

Some of the companies do not routinely provide reports or feedback to commissioning services on attrition rates which can contribute to this issue.

Selecting a digital therapy needs to be informed by the balance between cost and expected outcomes. One contributor felt that guidance on this would help their decision-making process when the EVA publishes.

One contributor referenced the difficulty experienced when commissioning a new treatment. The multiple levels at which decisions need to be agreed mean that the process is lengthy and cumbersome. This may act as a barrier to the adoption of these therapies other than silvercloud which is already offered in many areas of the country within IAPT services.

Resource impact

Cost was referenced by all contributors as being a potential barrier. Costs of the different products varies. Silvercloud charges a fee for a number of licences. These numbers are high and 2 contributors offering Silvercloud reported that using the amount purchased was not possible resulting in this option being expensive.

One contributor reported that the best price they could get for the various digital therapies offered was similar to the cost of providing traditional face to face therapy. They explained that there would be a capacity saving but only if the digital therapy was effective.

One contributor mentioned that their service was given access to a number of licences for some of the digital therapies detailed in the scope for free by the companies. This was/is so the companies can test their use in NHS services and begin to collect real world data. However- this contributor reported that to be able to continue with and roll out adoption- a cost/benefit assessment would need to be carried out.

Training

Time required to attend 1–2-day training sessions and then to gain a thorough understanding of the digital content may act as a barrier and lead to variation. All contributors reported that training was provided by the company/research trial team for free, and that time was also needed post initial training to work through and fully understand the content. This may lead to a resource impact especially as there is a high turnover of staff within these services. They also highlighted that as the learning is self-directed motivation of therapists would vary and therefore the knowledge and understanding of the digital therapy and how best to use it, could vary across regions and within a service.

As all the digital therapies allow the therapist to pick specific modules/content to direct a user towards, a good understanding of what's available within each program is required.

All also reported that there was a period of supervision required post training and this varied from once per week (until a person has been supported through use of the whole program/app), to weekly for 1 year.

Two contributors reported that the time invested in working through the programme was time well spent as it served to upskill therapists and therefore improve the quality of all interventions offered to people.

Clinician confidence

Two IAPT clinical service leads using iCT-PTSD as part of a research trial reported that the program has been developed by a highly respected team and has therefore created a trusted brand. They felt that the program mapped onto what would be provided by a face-to-face protocol well and that guided use enhances treatment rather than replicating it or offering a second rate option. These same two contributors also stated that the quality of the programme is such that it served to upskill them in their ability to work with people with PTSD.

One contributor explained that they are an adopter/implementer of digital therapy but are also cautious about their use. There are so many technologies to choose from

and development of them can be easy, so it is important to maintain QA processes and use ones that have demonstrable outcomes.

A clinical service director reported that Practitioners are trained to and enjoy speaking to people to deliver therapy and support them to problem solve. Practitioners may be reluctant to deliver care via a digital platform, though savings in time may incentivise this. This same contributor reported that PWPs have been trained to deliver therapy in a certain way. Changing this and incorporating use of a digital therapy may be difficult.

Practitioner/clinician capacity

One contributor reported that the delivery of guided therapy takes longer to begin with due to limited experience with the app. This gets better with time but is still a consideration for adoption as there is a high turnover of practitioners in IAPT.

Another contributor reported that whilst they found the ability to message clients and receive messages, between sessions, a positive factor, they thought that some clinicians might find this hard to manage / accommodate.

All contributors reported that once practitioners were familiar with using the technologies, capacity was released as less time was needed to deliver the guided element.

Data collection

There is a need to track outcomes whilst using these technologies. One contributor reported that their service uses an EMIS bundle system which tracks outcomes for free.

Two contributors explained the importance of data needing to cover the whole pathway as well as including information on rates and rational for drop out. These same two contributors reported that they don't currently collect data on re-referrals- i.e., numbers of people going through IAPT and needing help again in the future. This should be included, especially when using digital therapy to see if there is a difference.

As mentioned earlier in the report, some contributors reported that they rely on the company to provide them with access and outcome data. This means that companies are responsible for the data they provide. One contributor talked about the lack of transparency in this data and the limitations of real-world evidence data.

The contributor using Deprexis, explained that the company does not provide feedback on access and attrition rates. As this contributor follows up people referred for Deprexis access, they get the data this way, however this needs to be embedded in electronic patient record systems if wide scale adoption is recommended.

Two contributors using iCT-PTSD reported that outcomes using the program were good and recovery rates high. These same two contributors explained that data collection is embedded within the programme and that it is linked to the service electronic patient record system. This means that outcome data can be processed and analysed in the same way as the rest of the initiatives on offer.

Sustainability

One contributor expressed a concern about the sustainability of some of the companies behind the newer digital therapies supported by a small company team.

One contributor commented that using digitally enabled therapy may be more environmentally friendly as it limits the need for both the therapist and person to travel.

Patient choice

One contributor expressed a concern that offering guided digital therapy may limit patient choice. If a person is assessed as being more suitable for traditional CBT therapy, they should not be offered digitally guided therapy first to see if it works. People should have a discussion with their therapist and make a choice on what they think will be the best therapy type for them.

Patient experience

Iona Mind was referenced by the contributor offering this within their service as being more light touch and therefore easier for people to engage with than others. Some of

the digital therapies used by this service required people to read lots of material and complete lots of activities in between sessions.

Both contributors using iCT-PTSD reported that patient feedback has been positive. They stated that the positive elements of the program include; the ability for a person to log onto the programme at any time and watch/interact with content that is engaging, informative, empathic and motivating. For the therapist the ability to see what the person has viewed and the comments they have left were described as positive features. Additionally, the program has the ability to timetable messages to go to people at points relevant to the targets set which provides further support in between sessions.

One of the contributors using i-CT-PTSD reported that the programme includes features which are not possible to achieve through standard therapy, e.g., normalisation of symptoms through insight into other people's journeys (therapy stories and videos). The ability to see how someone else has experienced similar trauma and symptoms and how they have responded to different aspects of therapy was described as being powerful and effective.

The 3 contributors using Spring spoke about the positive feedback they had received on the continued access following discharge. People can access the programme for 3 years following discharge.

One contributor reported that for some people, their difficulties may be such that it is hard for them to face tackling them independently at home and then dealing with the impact on their lives (or feared impact). This should however be picked up at initial assessment and individuals in this category should not be referred for digitally enabled therapy.

6 Comparators

One contributor referenced using [Limbic](#) to support the management of referrals, initial assessment and provision of self-help. They referenced the fact that there is a recently available study which demonstrates that use of this app- leads to an improvement in outcomes.