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Internet-based psychological therapies: A qualitative study of National Health Service commissioners and managers views

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Objectives. To explore in-depth the views on Internet-based psychological therapies and their implementation from the perspective of National Health Service (NHS) commissioners and managers.

Design. Qualitative interview study.

Method. Ten NHS commissioners and managers participated in a semi-structured, co-produced interview. Each transcribed interview was double-coded and thematically analysed using The Framework Method.

Results. Interviews generated three main themes. (1) Capacity issues across psychological therapy services create barriers to face-to-face therapies, and Internet-based interventions offer a solution. (2) Despite reservations, there is growing acceptance of Internet-based therapies. Different ways of connecting with patients are required, and Internet-based treatments are accessible and empowering treatment options, with guided self-help (GSH) preferred. Internet-based interventions may however exclude some individuals and be a threat to the therapeutic relationship between patient and practitioner. (3) Successful roll-out of Internet-based interventions would be facilitated by a strong empirical- *or* practice-based evidence, a national coordinated approach and timely training and supervision. Barriers to the roll-out include digital intervention set-up costs and delays due to NHS inflexibility.

Conclusions. The study highlights factors influencing access to Internet-based therapies, important given the rapid evolution of e-therapies, and particularly timely given increasing use of remote therapies due to COVID-19 restrictions. Interviewees were open to Internet-based approaches, particularly GSH interventions, so long as they do not

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compromise on therapy quality. Interviewees acknowledged implementation may be challenging, and recommendations were offered.

Practitioner points

- There is a shift in practice and increasingly positive views from NHS staff around remote psychological therapies and different ways of connecting with patients, particularly since the COVID-19 pandemic.
- There is a strong preference for Internet-based psychological interventions that are guided and that include built-in outcome measures co-produced with service users.
- There is a need to raise awareness of the growing evidence base for Internet-based psychological therapies, including research examining therapeutic alliance across Internet-based and face-to-face therapies.
- Challenges implementing Internet-based psychological therapies include therapist resistance to changing working practices in general, and inflexibility of the NHS, and national, coordinated implementation efforts are encouraged.

We have witnessed an explosion in computerized and Internet-based interventions, otherwise known as e-health, over the last 20 years, enabled by the advent of the smartphone and evolution of Web 2.0 applications (Andersson, 2018; Gibbons et al., 2011). Internet-based approaches have the potential to revolutionize the ways that psychological therapies are delivered and offer potential as a cost-effective alternative to conventional in-person face-to-face treatment (Lewis, Pearce, & Bisson, 2012), prompting a growing interest in interventions placing less reliance on therapist time (Lewis, Roberts, Vick, & Bisson, 2013). Flexible treatment approaches may be important to people who are not able to commit to in-person sessions due to difficulty getting time off work to attend appointments, reduced mobility, financial, geographical restraints, or barriers such as fear of stigma (Lovell & Richards, 2000; Maercker & Knaevelsrud, 2007; Taylor & Luce, 2003). Remote therapies may be necessary for nearly all individuals some of the time, as demonstrated during the COVID-19 pandemic (Békés & Aafjes-van Doorn, 2020; Shore, Schneck, & Mishkind, 2020).

Internet-based CBT (i-CBT) commonly includes a series of modules, often interactive audio and video materials, with agreed homework tasks. Modules are typically delivered via a website browser or mobile App (Ebert et al., 2018) and are more commonly developed and offered in the context of mild to moderate severity disorders, but may be delivered at both low intensity (LI) and high intensity (HI) within stepped-care models (Bower & Gilbody, 2005). Interventions may be purely self-help, guided self-help (GSH), or a combination of face-to-face and Internet-based sessions, known as 'blended treatment' (BT; Wentzel, van der Vaart, Bohlmeijer, & van Gemert-Pijnen, 2016). The type and extent of guidance can vary widely between interventions (Simon et al., 2019). Internet-based interventions typically demand less therapist contact than face-to-face approaches and may be delivered by non-specialist clinicians, therefore impacting on therapist capacity, treatment access, and cost savings (Lindsäter et al., 2019; Thew, 2020). Greater effects have been shown for guided i-CBT (Andersson, Titov, Dear, Rozental, & Carlbring, 2019; Andersson, Topooco, Havik, & Nordgreen, 2016; Cuijpers, Riper, & Andersson, 2015; Carlbring, Andersson, Cuijpers, Riper, & Hedman-Lagerlöf, 2017; Lewis, Roberts, Simon, Bethell, & Bisson, 2019), and GSH is advocated within some NICE guidelines, including for depression, general anxiety disorder, panic disorder, and post-traumatic stress disorder (PTSD; NICE, 2009, 2011, 2018).

With the planned expansion of Improving Access to Psychological Therapies (IAPT) services (IAPT, 2021), and the increasing evidence for the effectiveness of i-CBT, it may be

timely to implement LI i-CBT approaches at scale within National Health Service (NHS) and other services. A survey of mental health services use of Internet-based therapies for stress, anxiety, and depression in England found inconsistency in their use and their recommendation across the country (Bennion, Hardy, Moore, & Millings, 2017), and LI treatment adoption in clinical practice remains limited (Mohr, Riper, & Schueller, 2017). Possible explanations include negative attitudes towards Internet-based interventions amongst staff responsible for their implementation and NHS system-wide implementation barriers. The therapeutic relationship is a key component of traditional psychological therapy, and psychologists and psychological therapists may have particular concerns that this cornerstone of therapy might be compromised by GSH.

Stakeholder perspectives of Internet-based therapies have been examined in European surveys with psychotherapists (Schuster, Topooco, Keller, Radvogin, & Laireiter, 2020; Topooco et al., 2017), and qualitative interviews with UK Psychological Wellbeing Practitioners (PWPs; Gellatly et al., 2017; Lovell et al., 2017). Findings have revealed flexibility and cost-efficiency to be perceived advantages, and therapeutic process concerns and implementation non-readiness to be barriers, with higher acceptance for GSH over non-guided approaches and for interventions treating mild forms of disorders. These themes were identified in a recent systematic review of health professionals' perspectives on implementing Internet-based therapies in routine mental health care (Davies et al., 2020).

Research conducted in the United Kingdom to date has focused on the views of PWPs and of health care professionals more generally (Gellatly et al., 2017; Lovell et al., 2017; Middlemass et al., 2012). Broader implementation of Internet-based therapies across the NHS requires knowledge of the views of NHS employees involved in intervention commissioning and implementation, given their unique position in understanding additional factors that are likely to impact this process. The aim of this study was to gather in-depth knowledge of NHS commissioners and managers views of Internet-based therapies and their implementation, to understand the factors that may impact on their successful roll-out across the NHS.

Method

Qualitative methodology was employed to gather in-depth stakeholder views, as a sub-study of the ongoing RAPID Trial (Nollett et al., 2018). RAPID is a pragmatic non-inferiority Phase III trial with nested process evaluation comparing the efficacy of an Internet-based GSH trauma-focused CBT (TF-CBT) intervention, 'Spring' (Lewis et al., 2017) with individual TF-CBT. Ethical approval for the study was granted by Wales Research Ethics Committee Panel 3 (ref 17/WA/0008).

Reflexivity

The first author, NS, interviewed all participants and analysed and interpreted 100% of the interview transcripts. NS is a 41-year-old White Welsh woman. NS conducted this research in the final year of her PhD studies of the acceptability of a GSH trauma-focused i-CBT intervention for PTSD. At the time of conducting the research, NS had no personal experience using an Internet-based therapy, nor of providing an Internet-based therapy to others in a clinical setting. NS has prior experience of conducting qualitative research; however, this was her first time using The Framework Method approach of thematic analysis. The second author, MP, analysed and interpreted 100% of the interview

transcripts. MP is a 31-year-old White English man, working as an Honorary Research Associate alongside the Traumatic Stress Research Group at Cardiff University. MP was not involved in the development of the 'Spring' programme and has not delivered Internet therapies in the past. MP had no prior experience of conducting thematic analyses. Authors CL and JB supervised the research and have experience conducting and supervising thematic analysis. As declared as a potential conflict of interest, JB and CL are developers of an Internet-based GSH programme 'Spring'; the intellectual property rights for 'Spring' are held by Cardiff University, and these co-authors may benefit financially if the intervention was to be commercialized in the future.

Participants and procedure

Sampling and interviews took place between January and June 2020. The study inclusion criteria were as follows: individuals in NHS roles likely to fund, commission, signpost-to, or implement an i-CBT intervention for NHS patients. Exclusion criteria were as follows: individuals with involvement in the RAPID Trial, or in the development of the 'Spring' intervention. We aimed to recruit ten individuals for sufficient information power, based on several considerations, including the specific study aim and sample specificity (Malterud, Siersma, & Guassora, 2016). Purposive sampling ensured participants with specific knowledge and experiences and a range of familiarity with Internet-based interventions, with representation across genders, RAPID recruitment sites, and NHS clinical leadership and management roles. Potential participants were identified by clinical members of the RAPID Trial Management Group and through discussions with interviewees. Twelve eligible individuals from England, Scotland, and Wales were invited and provided written informed consent to participate, although two were unable to progress due to unforeseen shifts in their role due to COVID-19.

Data collection and analysis

NS conducted interviews with participants in confidential NHS settings, in person (n = 3), on the telephone (n = 6), and via videoconference (n = 1), at a date and time convenient for the participants. All work was undertaken in full compliance with the General Data Protection Regulation.

At interview, demographic information was collected, and the interview followed a topic guide (see online Appendix S1), developed with input from researchers and clinicians of the RAPID Trial Management Group, co-produced with individuals with lived experience of PTSD (Cardiff University's Traumatic Stress Research Public Advisory Group), and an independent NHS Consultant Clinical Psychologist. A semi-structured approach was taken, which included prompts to probe for further views and detail and to maintain conversation flow. The tone was informal, and individuals encouraged to introduce new topics as they saw fit. Questions broadly invited discussion of the following topics: the participant's role, organization, and interventions they were involved with; their reflections on Internet-based interventions; and their understanding of the barriers and facilitators to implementing mental health treatment, including Internet-based interventions.

With each participant's agreement, interviews were recorded on an Olympus digital voice recorder, and field notes were written immediately after each interview to aid the preliminary analysis. Interviews were transcribed to produce orthographic verbal verbatim and audio recordings, and transcripts were uploaded and saved in a folder with restricted access permissions.

Data analysis occurred concurrently with its collection, adopting a constant comparison approach to explore themes. This allowed an extra check for sufficient data saturation (Saunders et al., 2018), in addition to our aim for sufficient information power via the recruitment of ten participants (Malterud et al., 2016). Saturation was monitored through the double-coding process and discussed between researchers NS, MP, and JB.

Transcripts were prepared for analysis. This included assigning pseudonyms for participants and removing the names of spoken others and their roles and institutions, to help preserve anonymity. Cleaned transcripts were imported into QSR NVivo 12 qualitative data analysis software (Q.I.P. Ltd., 2020), and NS and MP explored the range of views to be found in 100% of the transcripts. The Framework Method was used to support the thematic analysis, which allows for an inductive approach and provides a systematic model for managing and mapping data (Gale, Heath, Cameron, Rashid, & Redwood, 2013). We adhered to the principles of the Critical Appraisal Skills Programme qualitative checklist (C.C.A.S. Programme, 2019). An inductive approach was taken due to the theoretical flexibility, as well as the 'thick descriptions' afforded by the method (Braun & Clarke, 2006). NS and MP generated codes for 100% of the interviews, identifying interview segments that were analytically intriguing. NS and MP met regularly whilst coding, initially to develop an analytic framework from the coding conducted with the first few interview transcripts and thereafter to develop the analytic framework, for example as new codes were generated from further interviews. NS and MP then applied the analytic framework when coding the remainder of the transcripts and to finally populate the codes into a framework matrix. The matrix comprised rows based on participants and columns based on codes, with each cell therefore including verbatim quotes for the corresponding participant and code. See Table 1 for an extract of the matrix. NS and MP met with JB at regular intervals to discuss generated codes and themes and to be able to reconcile any inter-rater reliability discrepancies, and to ensure clear understanding and interpretation of themes. Final interpretations were made with oversight from JB and CL, and with input and support from LBH and KS, and Cardiff University's Traumatic Stress Research Public Advisory Group.

Results

Participant characteristics

As shown in Table 2, five males and five females participated, were mostly White British with a mean age of 50.7, and with a degree level of education or over. Interview lengths ranged from 27 to 62 min, with a mean of 48.9. Six interviews were conducted prior to the COVID-19 UK National Lockdown commencing 23 March 2020, and four were conducted after.

Analysis generated codes with three overarching themes and these are summarized in Table 3.

There are service capacity issues

Interviewees were invited to talk about interventions they were involved with and their understanding of the barriers and facilitators to accessing mental health treatment in general, including face-to-face, in-person therapies. Interviewees described capacity issues, stretched services, and the impact of this on patient access to treatment, evidenced

Table 1. Example section of Matrix with codes for participants (pseudonyms)

Pseudonym	*Theme - There are barriers to accessing individual, face-to-face psychological therapies, due to service capacity issues*		
	Service capacity issues are evidenced by unmet governmental targets, including waiting times, but the reliability of waiting times is debatable	There are service capacity issues due to high demand, and there are concerns about unmet needs and demands increasing	There are service capacity issues due to staffing and deployment issues, though the demand is still too high to be met by staffing solutions alone
Phil	'it's a complicated setup. . . It's quite easy for people perhaps to end up in the wrong bits of it or waiting too long for bits of it' '. . .the only measures we would have of whether we're providing access would be the waiting lists, cos as I've said already, these are not in any sense useful or reliable measures. They will simply show if there's a tail of people waiting a long time to access a particular therapy but they may simply be the tip of an iceberg of people who could theoretically benefit from that therapy and we don't know how big the iceberg below the water is. . . all we see is the tip of it which sometimes is quite substantial and sometimes is almost non-existent. . . It's an iceberg that floats up and down a bit'	'But you know, I think we've got to be realistic it might be that what will happen is as this becomes widely available and people know about it, erm we'll find that perhaps the threshold for referring into the system does gradually creep downwards a little bit and people who previously might not have been put forward for treatment, actually are now put forward for treatment. . .So that a previously unmet need might become a bit more apparent because we now have a service to provide'	when talking about why services are oversubscribed: 'there's a little bit of an issue with striking the balance between generic community mental health team psychology. . . which is actually very difficult to attract people into these days and the more specialist areas which tend to be much more popular, for example eating disorders and indeed, post-traumatic stress'

Continued

Table 1. (*Continued*)

Pseudonym	*Theme - There are barriers to accessing individual, face-to-face psychological therapies, due to service capacity issues*		
Tim	'anyone that is referred into, er, psychological therapies should be seen within 18 weeks, erm, but I think it's interesting that some of my understanding is that there's no board in [country] that's currently meeting that target. . . and that's across both adult services and CAMHS. . . for face to face therapy, erm, for the digital services we have a much, er, we don't have waiting list for the digital therapy, so the computerised CBT patients will tend to get access to the programme within five working days of being referred'	'there's the demand [for therapy], so and as we're, and digital technologies are becoming much more prevalent. . . they now recognise that the traditional models of service are not really going to meet that demand if the rates continue'	'. . .even in those areas where they do have a full, er complement of staff that you tend to find that there's high demand of services. . .. as investment has been put in, you know, increasing the workforce but the demand is still going up. . . and digital technologies are becoming much more prevalent. . . Because they now recognise that the traditional models of service are not really going to meet that demand if the rates continue'

Table 2. Participant (pseudonym) characteristics and interview length

Pseudonym	Gender	Age	Ethnic origin	Type of NHS role	Length of interview (min)	Interview conducted Pre/Post 23rd March COVID-19 UK lockdown
Phil	Male	59	White British	Clinician Clinical service management	50	Pre
Tim	Male	44	White British	Clinical service management	57	Pre
Sue	Female	59	White British	Clinical service(s) strategic lead	56	Pre
Patrick	Male	51	White British	Clinical service management	57	Pre
Isla	Female	55	White British	Clinical service(s) strategic lead	43	Pre
Geoff	Male	53	White British	Clinical service management	47	Pre
Sarah	Female	49	White British	Clinician Clinical service(s) strategic lead	40	Post
Robert	Male	34	White Irish	Clinical service management	62	Post
Gwendolyn	Female	52	White British	Clinical service(s) strategic lead	27	Post
Rose	Female	51	White and Black African	Clinician Clinical service management	50	Post

Table 3. Summary of themes

Theme 1 There are service capacity issues	
Unmet governmental targets, including waiting times, but the reliability of waiting times is debatable	
High demand, and there are concerns about unmet needs and demands increasing	
Staffing and deployment issues, though the demand is still too high to be met by staffing solutions alone	
Theme 2 There is a movement towards the acceptance of Internet-based psychological therapies	
Reservations	Interviewees perceived that patients might expect therapy to be delivered traditionally, face-to-face
	Internet-based approaches are considered an 'add-on'
	Concerns about patients using Internet-based interventions in the proximity of others
	May exclude some individuals in terms of literacy and computer access, literacy, or compatibility issues
	Interviewees perceived staff may not know enough about an intervention and who it is aimed at helping
	Interviewees perceived staff might be resistant to changing their approach and might consider Internet-based interventions to be a threat to how they interact with and work with people, for example a threat to the therapeutic alliance relationship
Acceptance	Interviewees perceived that some patients may prefer therapy that is more remote
	Interviewees perceived patients valuing the ability and convenience of accessing Internet-based treatments at their own pace and at their own time
	Interviewees perceived patients valuing the ability to access the online intervention and its tools after the treatment period had ended
	Different ways of connecting with patients are required, and the structured format of CBT lends itself to be delivered in a variety of formats
	Can and should be accessed quickly after screening and assessment
	Empowering treatment approaches for individuals with mild to moderate severity conditions
	Suitable as first stage interventions for people with more complex or severe conditions

Continued

Table 3. (*Continued*)

Theme 2 There is a movement towards the acceptance of Internet-based psychological therapies	
	Advantages to offering Internet-based interventions to individuals in primary mental health services, rather than referring those individuals to other services for treatment
	Preference for Internet-based psychological therapies that are guided, with guidance seen to be important for treatment uptake and engagement, and treatment enrichment
	Guidance need not be with a clinician nor a higher intensity therapy contact
	Internet-based interventions can include built-in outcome measures and risk assessment
Theme 3 There are considerations for the successful implementation of Internet-based interventions	
The evidence base is an important but not a sufficient factor in the implementation of an intervention and its acceptance amongst NHS staff	
NHS Information Governance procedures can be a barrier	
NHS funding issues, including uncoordinated budgetary control, competing budgets, and potentially prohibitive intervention set-up costs, can be a barrier	
A culture promoting digital health can be a facilitator	
A coordinated nationwide approach to implementation, including commissioning services at scale, can be a facilitator	
A clear understanding of implementation requirements, with no hidden surprises, can be a facilitator	
External opportunities, including external directed funding and changing circumstances such as during the COVID-19 pandemic, can be facilitatory	
The availability of timely training and supervision can be a facilitator	

by unmet governmental targets. The reliability of waiting times as a measure of treatment access was debated, although long waiting times were identified as being of concern.

Tim described difficulties meeting targets for face-to-face therapy: 'anyone that is referred into, er, psychological therapies should be seen within 18 weeks, erm, but I think it's interesting that some of my understanding is that there's no board in [country] that's currently meeting that target... for face to face therapy'.

Explanations for service capacity issues were offered, including a high and increasing number of referrals, complicated referral pathways, and issues around funding, staffing, deployment, and supervision.

Rose talked about limited resources: 'people come and they want to be treated straight away don't they and to keep them waiting is, is a challenge when you know, actually a lot of that is about resources when you've just got one therapist and one team... What can you do?' Patrick also noted staffing as a barrier to treatment access, 'there's a national shortage of err particularly step 2 [low intensity] but also step 3 [high intensity] people [staff] who have undertaken an a accredited err recognised HIT [High Intensity Training] training course at step 3, so CBT therapists, or and the PWPs in terms of there just aren't enough of them... the demand outstrips the supply of trained therapists'.

Interviewees suggested staffing and deployment solutions alone would not be sufficient in increasing patient access to therapies. Tim stated '...even in those areas where they do have a full, er complement of staff that you tend to find that there's high demand of services.... as investment has been put in, you know, increasing the workforce but the demand is still going up... and digital technologies are becoming much more prevalent... Because they now recognise that the traditional models of service are not really going to meet that demand if the rates continue'.

There is a movement towards the acceptance of Internet-based psychological therapies

Various attitudes towards Internet-based therapies were expressed, including interviewees own views and perceived views of patients and colleagues. A movement towards digital proficiency and acceptance of Internet-based therapies was described, for example when reflecting on a digital intervention for depression, Sarah remarked 'It wasn't very, wasn't successful, um, the uptake of licences was very low, but I think people's digital... capability was lower back then'. Reservations were also raised, and these are presented first.

Reservations about Internet-based psychological therapies. Interviewees perceived that Internet-based approaches were an 'add-on' and that patients might expect face-to-face therapy. Patrick suggested 'often patients don't want group offer or e-therapy, they want to see somebody'.

Concerns were raised over patients' use of Internet-based interventions in the proximity of others, for example those with whom they live. Rose was interviewed post-COVID-19 UK lockdown and talked about this: 'So one of the things we've learnt with, with this...pandemic is there's a challenge around people doing therapy in their own home you know... particularly in trauma when you may have you know, perpetrator or something like that in the next room... about safety and boundaries'.

The potential for Internet-based treatments to exclude some people due to literacy, computer literacy, and access issues, was raised as a concern. Gwendolyn talked about this: 'there are individuals who don't have access to phones that are able to use that kind

of... this kind of technology. Nor do they have access to, you know laptops and other ways of working. So, I think there is a concern about if we have a more blended approach... perhaps some of the individuals who are hardest to reach, who most need psychological interventions, aren't going to be able to access it easily with that approach'.

Interviewees perceived limited staff knowledge of Internet-based interventions and who they are aimed at helping. Tim remarked, 'there's still quite a lot of, er, misconceptions about what computerised therapies are or internet interventions are'.

Interviewees perceived staff resistance to change. Sue suggested, 'people often don't like changing what they're already doing...sometimes, um, you almost have to get to the point where people understand they can't carry on delivering things a certain way, before you all realise other opportunities'. Rose reflected on resistance to telephone-based assessments prior to the COVID-19 pandemic and how 'the staff didn't want it to succeed and it didn't succeed. Now, we're talking about you know, telephone assessments are fantastic, we've been able to keep the service going, we must do more of these'. Reservations also included perceptions of internet-based interventions being a threat in terms of how staff interact with and work with people, for example Tim talked about 'pushback' due to clinicians'...'strong belief on the kind of therapeutic relationships that occurs between the clinician and patient'.

Acceptance of Internet-based psychological therapies. Whilst interviewees perceived patients expecting face-to-face approaches, interviewees also perceived that some patients may prefer therapy that is more remote and that Internet-based interventions may facilitate openness. Isla suggested 'I think some people would want to see somebody face-to-face initially and actually might be more comfortable doing something through the internet or through, a bit more remote...' Robert, who was interviewed post-COVID-19 UK lockdown, reflected on his experience of people entering information into a website 'more openly than they would face-to-face'.

Interviewees preferred guided Internet-based therapies over self-directed therapies, with guidance viewed as important for treatment uptake, engagement, and enrichment. Phil said 'it would probably be a good idea for somebody using this method-based therapy to actually come into some centre and... sit down with a person who's very familiar with the material... that person would meet them again and ask how things are going... it might be some little areas that aren't quite covered perhaps they're a bit tangential and the individual therapist then might be able to just enrich the process further by adding some... localised idiosyncratic examples or ways of expressing certain concepts'. Geoff weighed up the costs and benefits of clinician guidance in GSH: 'adding a lot of layer and more money because you've got a one to one session with a clinician, but if it gets them in and using it then that's probably going to be quite useful'. Interviewees expressed the opinion that guidance need not necessarily be provided by a clinician, but it would depend on skills required. Rose suggested, 'so is it something that could be done by somebody with level one skills or do you need to have somebody who's got a therapy training, who erm, who knows [pause] erm, who knows more than that that is provided in the actual treatment'.

Interviewees highlighted the advantages of Internet-based interventions with in-built outcome measurement and risk assessment. Intervention usability, treatment satisfaction, and goal attainment questions were provided as examples of built-in measures. Interviewees discussed the importance of service user involvement and co-production, in particular with the development of outcome measures, for example Sue said, 'the

outcome for me is what the service user thinks is the outcome'. Sarah talked about the importance of an intervention linking outcome data with NHS patient record systems and key performance indicators: 'otherwise we've got an administrator going into the programme, getting the data off, taking that data to another programme. . . it creates the potential for an Information Governance risk'.

Interviewees perceived that patients would value the convenience of accessing treatments at their own pace, in their own time. Gwendolyn, interviewed post-COVID-19 UK lockdown, suggested Internet-based interventions were 'a really important part of the suite of offers that we have for patients. . .. there are also real benefits in terms of being able to provide that kind of input for people at a time and place that most suits them, as opposed to needing to make appointments with an individual during the day which may not be convenient for the patients'. The potential for continued access to the Internet-based intervention after the treatment period had ended was also considered a positive, for example Isla said 'it may be something you would then want to go back to the beginning and do again'.

Geoff acknowledged that different ways of connecting with patients are required: 'I think that's come through in our staff group here is that we've got to think of different ways of connecting with our patients'. Interviewees remarked upon the structured format of CBT, which lends itself to be delivered in a variety of formats. Phil suggested 'it [CBT] is very much an educational approach. . . And there's no earthly reason why it shouldn't be delivered in a structured classroom format or indeed, lends itself perfectly to deliver on the internet. . .'.

The potential for quick access to Internet-based interventions was viewed positively. Patrick suggested 'there is some evidence I think that err people who wait longer have poorer outcomes, so the quicker you can start treatment the better, for me that's a plus, it helps the patient err and it also helps towards our waiting times, achieving our waiting time targets, so it's a win-win'.

Interviewees suggested Internet-based interventions were empowering treatment approaches for people with mild to moderate severity conditions. Gwendolyn said: 'if, for instance, somebody has milder levels of, erm, psychological morbidity or mental illness and they are able to engage in those kind of [internet-based] interventions then they are going to find it empowering'. Sue expressed this further, with respect to general health care movements encouraging people to take responsibility for their health, stating 'unless we find a way of helping people be more open and take responsibility for their own health, and access stuff that's really good for them on the internet and things like that, we will never manage to reach them all'.

Interviewees were positive about offering Internet-based interventions within primary mental health services, for example Geoff said: 'We are very keen to be offering interventions for that [primary care] cohort rather than referring on. . . If we can be offering interventions at the right level. . . we want to be doing that'. Sarah remarked upon the advantages of Internet-based interventions as first stage interventions for people with complex or severe conditions: 'I think we have to have a digital, a digital first mentality. . . the least intensive intervention first, see how somebody responds to that. . . if somebody does need a kind of one to one situation, that's gonna cost a lot of money, that we haven't got a lot of people delivering, at least it's reserved for the people who really, really need it. . .'.

There are considerations for the successful implementation of Internet-based interventions

NICE and other country-specific guidelines and practice-based evidence were considered an important but, interestingly, not a sufficient factor for intervention implementation and

acceptance amongst staff. Sue noted NICE guidelines, 'should be part of the conversation and evidence is really important, but it's not you know, sometimes we don't have the evidence and we just have to try things'. Rose expressed her interest in practice-based evidence, 'randomised control trials are great but what they miss is most people that come to our door are not, you know, a neat little box or they're not going to fit into a neat little box. . . so I suppose it's, I'm very much in favour of practice-based evidence'.

NHS inflexibility was considered a barrier. Sarah stated: 'we have been a bit slow on the uptake, it, it's really about the way I think the NHS bureaucracy works, a lot of the time, it doesn't allow itself to have the agility to implement. . .' Tim expressed problematic implementation delays due to information governance and procurement processes: 'within digital what you're trying to do is streamline the processes as quickly as possible because the technologies always evolving and changing and if it takes you two years to get past information governance and procurement then actually you're already two years behind where the technology is'.

Interviewees highlighted NHS funding barriers. Phil explained: 'there isn't one overarching form of budgetary control. . . So you could argue there isn't a great deal of central coordination because of that'. Tim reflected on an experience of potentially prohibitive intervention set-up costs: 'one of the biggest barriers, er, when we initially tried to bring CCBT [computerised CBT] into [country] was the cost of the product. . . the actual ability for them [smaller health boards] to, erm, purchase the product in addition to then the service infrastructure means that many, many areas, particularly smaller board are prohibitive to the set up'.

Sarah suggested Internet-based interventions would start to happen with a 'change in culture from Commissioners and that comes from the top. . . If it was expected that you know, um, seventy five percent of your workforce were bums on seats and twenty five percent was digital. . . cos it would hold that accountability in the system'. Tim reflected on a positive experience of a coordinated national approach and commissioning services at scale: 'We have one implementation approach which we did across [country] but. . . we built into the implementation programme ability to then allow people to go different speeds. . . with a national deployment. . . you're able to then look at the costs and identify what the big costs are, and then extract them. . .. within [country] we fund the national CCBT licence for the whole of the country. . .. for every single person'.

Knowledge of set-up *and* ongoing requirements was recommended. Isla said: 'setting up a service you would have sort of initial costs. . . And then the ongoing costs. . . So it could be that every year they [staff] go on a refresher training or, so you. . . just build that in really so you haven't got any surprises really'. Rose reflected on her experience regarding timely training and supervision as a facilitator: 'So a therapist came to me saying, look there's this training and at the end of it I get a, erm a treatment manual that's tailored to our service and I'll be up and running and ready to run this group immediately after I've finished this course. . . that's quite a big selling point. . . something that is erm, accessible and useful straight away so that after a training in it, people could, could run with it very quickly. . . maybe after training thinking about some supervision. . . to enable implementation and to pick upon any problems'.

Interviewees reflected on implementation facilitated through opportunistic ventures. Isla talked about external directed funding: 'a lot of investment for new service tends to come from directed investments. . . [country] Government may decide they want to invest in that area . . .' Sarah, interviewed prior to the COVID-19 UK lockdown, reflected: 'I think COVID's helped. . . We've just managed to get Silver Cloud [internet-based intervention

for stress, anxiety and depression] in, um I've been struggling for two years... and suddenly we've got it within three weeks...'.

Conclusions

Summary of findings

Ten commissioners and managers took part in qualitative interviews and provided their opinions about the potential and challenges of providing Internet-based therapies. Interviewees identified service capacity issues; a movement towards the acceptance of Internet-based psychological therapies (acceptability as well as reservations); and acknowledgement for considerations in their successful implementation.

Internet-based therapies were generally considered suitable for mild to moderate disorders, reflecting previous findings (Davies et al., 2020; Gellatly et al., 2017; Schuster et al., 2020; Topooco et al., 2017), and in line with recommendations by NICE, as first stage treatments in stepped-care models (Stephen, Whittington, Taylor, & Kendrick, 2011). A strong preference for guided interventions was clear, to assist with treatment engagement and enrichment. This is encouraging given GSH i-CBT is recommended in NICE guidance, for example for depression and PTSD (NICE, 2009, 2018), with guided interventions demonstrating greater effect compared with self-help in a Cochrane systematic review (Lewis, Roberts, Bethell, Robertson, & Bisson, 2018).

Reservations about Internet-based approaches included perceptions that therapeutic alliance may be threatened. A review of therapists' beliefs about Internet-based approaches (Thew, 2020) reported similar views. These views are not, however, supported by the available evidence where equality of alliance in online and face-to-face therapy is suggested (Andersson et al., 2012; Berger, 2017; Hadjistavropoulos, Pugh, Hesser, & Andersson, 2017). Interviewees also perceived that Internet-based approaches may exclude some people due to literacy and online access issues. Indeed, literature exists highlighting the tendency for digital technologies to increase inequalities, for example with respect to increased age and lower level of educational attainment (Azzopardi-Muscat & Sørensen, 2019); further research is required.

Unsurprisingly, and in line with evidence-based medicine approaches, a strong evidence base for an intervention was considered by interviewees to be a facilitator in its implementation and acceptance amongst staff. Of concern however was the finding that the evidence base is an important but not always a sufficient factor. This reflects literature suggesting that clinicians may value personal clinical experience over research evidence, particularly when the available evidence fails to address some real-world clinical contexts (Timothy, Richard, & Varda, 2008). It also reflects findings that of the 191 IAPT services who provided information, 169 (88.5%) recommended the use of online interventions as part of their service provision, though of these c-CBT interventions, only 24.3% were NICE-recommended (Bennion et al., 2017).

Interviewees suggested coordinated nationwide approaches and timely training and supervision as other facilitators in an intervention's implementation, and digital intervention set-up costs and delays due to NHS inflexibility were considered barriers. Contrary to the views expressed in previous surveys (Schuster et al., 2020; Topooco et al., 2017), it was this inflexibility to facilitate successful, timely implementation that was expressed as a barrier, rather than *non-readiness*. Indeed, it was clear, particularly from codes generated from the four interviews that were conducted post-COVID-19 UK National lockdown, that there is a shift in practice and increasingly positive views from

staff around remote therapies and different ways of connecting with patients. This is supported by recent literature which considers COVID-19 as the 'black swan' and a turning point for mental health care and increased e-Health (Wind, Rijkeboer, Andersson, & Riper, 2020).

Strengths and weaknesses

As far as we are aware, this is the first in-depth exploration of NHS commissioners and managers views of Internet-based therapies and their implementation. The findings are important given a drive towards IAPT, the increasing number of Internet-based interventions and a growing evidence base. The findings are particularly timely given the necessities to provide more remote therapies because of COVID-19 restrictions, and since we conducted interviews both pre- and post-lockdown restrictions, the information provides a unique insight into shifting practices and views as a result of the pandemic.

We aimed for sufficient information power via the recruitment of ten participants, based on the specific aim of the study, the specificity of the sample, being individuals working in specific NHS roles with specific knowledges and experiences, and the strength of the in-depth interview dialogue (Malterud et al., 2016). Purposive sampling supported this approach and ensured representation from across England, Scotland, and Wales, across genders, and across NHS clinical leadership and management roles. The semi-structured interview method provided a rich set of data, with openness for individuals to present new topics. Lived-experience contribution and double coding of all interview transcripts are also strengths. Whilst the spread of male and female participants was equal, most individuals were White British. All but one of the individuals were over the age of 44, all with a degree level of education, or higher, though arguably the age and education level demographics reflect an accurate representation of individuals responsible for implementing NHS mental health interventions.

Research implications

Given that the goal of researching an intervention should go beyond its efficacy, to its sustainable implementation into routine care, this research is crucial, since it highlights factors impacting the timely and sustainable roll-out of Internet-based therapies across the NHS. Further research exploring these factors is, however, required to provide further evidence to help corroborate or dispel ambiguous perceptions.

Interviewees emphasized the importance of both empirical and practice-based evidence, suggesting that further work is needed. Updated systematic reviews of Internet-based therapies are required to evaluate efficacy and acceptability in a rapidly evolving field. RCT research is currently underway exploring perspectives of patients and therapists (Nollett et al., 2018), and it would be beneficial also to research these perspectives in the context of routine NHS practice. Interviewees perceived that Internet-based approaches may exclude some people due to literacy and online access issues. Understanding the extent to which individuals may or may not be excluded from Internet-based treatment due to literacy or computer literacy issues is important, to ensure any inequity may be addressed. A strong preference for guided interventions was a clear finding, and further studies are needed to investigate the optimal guidance for effective GSH and to what extent Internet-based therapies may be able to play a part in the treatment of people with the most complex needs (Ashwick, Turgoose, & Murphy, 2019; Olff et al., 2019; Wilson & Zandberg, 2012). As noted previously, the perceptions of the

therapeutic alliance being threatened in Internet-based therapies do not reflect research findings to date; however, further RCT research is required (Andersson et al., 2012; Berger, 2017; Hadjistavropoulos et al., 2017).

Clinical implications

The findings of this research highlight the need to raise awareness of the evidence base for Internet-based therapies to dispel misconceptions, for example the view of inequity of therapeutic alliance across Internet-based and face-to-face therapies. The finding that the evidence base is considered an important but perhaps not an essential factor in an intervention's implementation should be explored and challenged. Importantly, the findings allow for recommendations to be made, including the following: developing interventions with built-in outcome measures, measures that are co-produced with service users (Crawford et al., 2011); timely training and supervision for competence in intervention delivery; allowing treatment materials to be accessed by patients beyond the treatment period; and utilizing implementation opportunities afforded by national and coordinated efforts.

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Conflicts of interest

All authors declare no conflict of interest.

Author contribution

Natalie Simon (Conceptualization; Formal analysis; Investigation; Methodology; Project administration; Software; Validation; Visualization; Writing – original draft; Writing – review & editing) Matt Plosjaski (Formal analysis; Methodology; Validation; Writing – original draft; Writing – review & editing) Catrin Lewis (Conceptualization; Methodology; Supervision; Validation; Writing – original draft; Writing – review & editing) Kim Smallman (Conceptualization; Methodology; Writing – original draft; Writing – review & editing) Neil Roberts (Conceptualization; Funding acquisition; Supervision; Writing – original draft; Writing – review & editing) Neil Kitchiner (Conceptualization; Funding

acquisition; Supervision; Writing – original draft; Writing – review & editing) Lucy Brookes-Howell (Conceptualization; Methodology; Resources; Writing – original draft; Writing – review & editing) Jonathan Bisson (Conceptualization; Formal analysis; Funding acquisition; Methodology; Supervision; Validation; Writing – original draft; Writing – review & editing).

Data availability statement

The data comprise participant demographic information, the entirety of which is provided in this manuscript, and semi-structured qualitative interview transcripts. Full interview transcripts will not be placed in a repository since participants have not consented to this, and the confidentiality of participants may be compromised. Anonymised quotes from interviews are provided within this manuscript, as consented by participants.

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Supporting Information

The following supporting information may be found in the online edition of the article:

Appendix S1. Topic Guide.