**Abstract**

**Background**

Ensuring rapid access to psychological interventions is a priority of mental health services. Current service initiatives address some of the demands, but further exploration of provision is required. The involvement of peer workers to support the delivery of more accessible treatment options such as computerised cognitive behaviour therapy (CCBT) is recognised to further address issues of choice and accessibility.

**Aims**

To evaluate the implementation of a third sector remote CCBT @Home eTherapy service for people experiencing common mental health problems supported by individuals with lived experience.

**Method**

The service provided clients with access to an appropriate online CCBT package with telephone support. Self-complete measures identifying levels of depression, anxiety and functioning were administered at each treatment appointment. Data for clients accessing the service over a 30-month period was collated.

**Results**

Over 2000 people were referred to the @Home eTherapy service, two thirds attended an initial assessment and 53.4% of referrals assigned to CCBT completed treatment. Statistically significant improvements in anxiety, depression and functioning were found, with 61.6% of treated clients meeting recovery criteria.

**Conclusions**

The service is comparable to Improving Access to Psychological Therapies (IAPT) key performance targets in services using CCBT in relation to recovery. Evidence for the successful implementation of such a service by a third sector organisation is provided. Generalisability is limited as analysis only took place for clients who had ‘completed’ treatment and due to the underrepresentation of some groups including older adults and BME communities. Future research should address identifying elements of providing interventions supported by individuals with lived experience that are important for success and exploring ways that accessibility for all individuals may be improved.

*Key words*: @Home eTherapy, Computerised cognitive behavioural therapy, CCBT, self-help, depression, anxiety

**INTRODUCTION**

The increasing prevalence of mental health problems places considerable pressure on mental health services, economic productivity and well-being, and the capacity to provide adequate services is often outrun by the demands of patient need. Achieving equitable, accessible and acceptable services is a challenge. A number of initiatives implemented within the UK, including the Improving Access to Psychological Therapies (IAPT) programme (DH, 2015; 2008), have aimed to identify new and effective approaches to the delivery of services (Williams and Martinez 2008; Gellatly, Bower, Hennessy, Richards and Gilbody, 2007). Dependent on presentation, a “*relatively brief low-intensity intervention*” (DH, 2008, p. 22) is recommended in the first instance. These include supported self-help interventions based on cognitive behavioural therapy (CBT) principles such as computerised CBT (CCBT, National Institute for Health and Clinical Excellence, NICE, 2011). Research to date has highlighted the effectiveness and acceptability of CCBT for common mental health problems (e.g. Grist and Cavanagh 2013; Kaltenthaler, Sutcliffe, Parry, Beverley and Rees 2008), and additional benefits such as facilitating learning and retention (Andersson and Titov, 2014). Third sector services are increasingly being commissioned by NHS bodies to deliver such services (Miller, 2013).

There has been a rise in the demand for psychological therapies and evidence suggests that some people may prefer psychological interventions in comparison to pharmacological interventions (McHugh, Whitton, Peckham, Welge, and Otto, 2013). It is therefore paramount that models of psychological treatment delivery that address this demand are considered and implemented.

The shift within mental health services to promoting patient choice, adopting a holistic approach and the value of lived experiences is evident in guidance, policy and research (e.g. NHS England 2014, Health Foundation 2014). In acknowledging this, growing attention is being given to the fundamental role that peer workers play in ensuring mental health needs are met (e.g. Mahlke, Kramer, Becker and Bock 2014, Lawton-Smith 2013). The implementation of peer support is diverse and definitions vary considerably. Despite this the underlying presumptions of offering support from individuals who have similar experiences to those accessing services is shared. It is argued that not only the individual receiving the support benefits but also the peer worker themselves, with resulting positive outcomes for mental health services. Peer support services are thought to support a unique relationship providing the opportunity for people with similar experiences, on a reciprocal basis, ro offer ‘*more authentic empathy*’ (Bailie and Tickle 2015, pg 48) in using their own experiences as a tool in the journey to recovery.

The incorporation of peer support worldwide is expanding, although great diversity in implementation within services exists (Mahlke, Kramer, Becker and Bock 2014). The emerging evidence-base is promising (e.g. Faulkner and Basset 2012, Fuhr, D.C., Sailsbury, T.T., De Silva, M.J., Atif, N., van Ginneken, N. et al 2014) but highlights more research on effectiveness (e.g. Fuhr et al 2014) and implementation (e.g. Gillard, Holley, Gibson, Larsen, Lucock et al 2015; Davidson, Bellamy, Guy and Miller 2012) is required.

This paper presents an evaluation of the implementation of an innovative home-based CCBT service provided by Self Help (previously known as Self Help Services), a service-user led, third sector organisation based in Greater Manchester, commissioned by Manchester Clinical Commissioning Groups (CCGs). The @Home eTherapy service provides clients the opportunity to access one of a variety of CCBT programmes, supported by a peer worker that best meets their needs. Outcomes from the service will be reported and compared with IAPT Key Performance Indicators (DH, 2008) and IAPT national service data (HSCIC, 2016).

**METHODS**

**The service delivery model**

Self Help is a mental health charity that provides a range of socially inclusive support, services and opportunities for people living with common mental health problems. It is commissioned by the NHS to deliver a range of psychological treatments to people living in the North of England. Over 60% of the staff have personal experience of living with a mental health problem. Self Help have been offering CCBT services since 2007, and have reported practice based evidence of these services meeting IAPT service expectations (Cavanagh, Seccombe and Lidbetter, 2011).

The @Home eTherapy service provides telephone-supported CCBT to clients to access in their own home. Treatment appointments, delivered over the phone by an eTherapy coordinator, recruited based on lived experience of mental health problems. The majority have a psychology degree, but a formal qualification is not required. All coordinators are paid staff members and partake in an induction period lasting two weeks which includes shadowing of experienced eTherapy coordinators, skills training covering patient-centered assessments, CCBT programmes used within the service, risk management, safeguarding and managing barriers engaging with eTherapy. The coordinators provide emotional support and work with clients to problem solve any implementation or technical difficulties they are experiencing. The support provided is considered as less directive than that provided by other practitioners working within IAPT services. Coordinators generally hold caseloads of approximately 25-35 clients. They are supported by monthly group clinical supervision. Risk to self (i.e. self-harm or suicidal ideation) identified through discussions and in response to risk alerts sent by the program is monitored by coordinators who liaise regularly with clients’ GPs to inform them of risk, change in symptoms and discharge outcomes and act as a gateway into other services.

**Service procedures**

The eTherapy services in this study are implemented in three geographical areas in the North West of England. Referrals are accepted directly from GPs, from other health professionals (e.g. health trainers, support workers, employment support), triaged from other step two services (e.g. Psychological Wellbeing Practitioners) and from clients themselves. One @Home service additionally accepts referrals from a single point of access service that provides a first point of contact for people requiring access to mental health services. The service offers mental health triage to enable individuals to be directed to the most appropriate service.

Contact is made with clients and their GPs within two weeks. An initial telephone assessment with an eTherapy coordinator takes place, during which general demographic, physical and mental health information is discussed and outcome measures completed. Client needs and preferences are taken into account to determine whether the service is suitable. Individuals presenting with depression, anxiety, stress, low self-esteem, panic or insomnia and are willing to receive support and work on the ‘here and now’ aspects of their problems are eligible. Those presenting with serious mental illness such as psychosis or PTSD or immediate risk would be referred to alternative services. For those for whom it is deemed suitable, an appropriate CCBT package is identified based on their presenting problem and personal treatment goals, log in details are provided and clients are informed that they should aim to complete one online module per week. A coordinator contacts clients at a prearranged time each week to discuss the content and review outcome data. Clients are offered one assessment appointment and between six to twelve 20 minute support calls, dependent on the program. Phone appointments are offered up to 8pm on weekdays, and access to the CCBT program is 24/7. After the final online module, and during the client’s final support call, the coordinator will discuss with the client their views of the CCBT program and identify if further support is required. Clients accessing the service also have the opportunity to access other services offered by Self Help outside of the IAPT service, including anxiety and depression drop-in groups and *The Sanctuary* crisis service. GPs are informed of discharge and any associated relevant information about outcomes, risks, referrals or recommendations.

***eTherapy programmes***

Several specialist online computerised programmes are available through the @Home eTherapy service to improve common mental health problems and associated symptoms. Each are based on CBT principles with the underlying focus on assisting people to understand how their thoughts impact on their feelings, physical symptoms and behaviour. These programs include:

*Living Life to the Full Interactive (LLTTFi)* (Williams, 2008): a six-session online skills enhancing programme to help people more effectively respond to everyday demands. Practical sessions such as anxiety control, identifying and changing unhelpful thoughts, problem solving and healthy living are included. Audio and visual clips alongside text are incorporated, supplemented by weekly tasks, handouts and discussion forums. Preliminary findings from pilot and feasibility studies indicate positive impacts on outcomes, but not necessarily service utilisation (McClay et al 2015; Pittaway, Cupitt, Palmer, Arowobusoye, and Milne, 2009).

*SilverCloud Health* (http://www.silvercloudhealth.com): an internet-based platform that delivers online therapeutic and psycho-education for common mental health problems, including depression, stress, anxiety and eating disorders using interactive modules. A variety of tools, such as videos, quizzes and text/email reminders are incorporated and the user has the ability to personalise the platform. Early evaluations show improvements to symptomatology and good acceptability (Sharry, Davidson, McLoughlin, and Doherty, 2013).

*Beating the Blues* (Proudfoot, Goldberg, Mann, Everitt, and Marks, 2003): an interactive multimedia program that consists of eight sessions for depression and anxiety including identifying treatment goals, challenging unhelpful thinking/beliefs, understanding and addressing attributional styles and coping with setbacks. Initial developer-led randomised controlled trials endorsed the use of the program (Proudfoot et al) but more recent trials have not found significant improvements to depression in comparison to usual GP care (Gilbody, Richards and Barkham 2015).

*Breaking Free* (https://www.breakingfreeonline.com): an online treatment and recovery programme for people experiencing substance misuse difficulties. It provides individuals with a toolkit to assist them to develop a personalised knowledge and skills base. A growing evidence base of outcomes studies have identified improvements in substance use functioning and clinical outcomes (e.g. Elison, Humphreys, Ward, and Davies, 2014; Elison , Davies, and Ward 2013).

*Sleepio* (https://www.sleepio.com): an online six-week sleep-improvement course. Clients receive access to online tools and information sources and can complete a sleep diary. In a randomised controlled trial in comparison to treatment as usual and placebo therapy it has proven to be effective in improving sleep and daytime functioning for adults with insomnia disorder (Espie, Kyle, Williams, Ong, and Douglas, 2012). Pilot trials have also identified its impact upon improving mood and reducing anxiety (Pillai, Anderson, Cheng, Bazan, Bostock, 2015).

***Measures***

To explore the impact of the implementation of the service, and to allow for a comparison with current mental health service outcomes, data from clients who were referred to/attended the @Home eTherapy services was collated. On commencing, during and at the end of treatment clients were asked to complete a number of measures to assess severity and monitor change. Measures included some of those routinely used as part of the IAPT minimum data set (DH, 2008):

*Patient Health Questionnaire* (PHQ-9; Kroenke, Spitzer and Williams, 2001): a nine-item self-report scale, which facilitates the recognition and diagnosis of depression. Scores range from 0 to 27, a score of 10 or more indicates a clinically significant level of depression. The PHQ9 has demonstrated good reliability and validity (Gilbody, Richards and Barkham, 2007).

*Generalized Anxiety Disorder Scale* (GAD-7) ; Spitzer, Kroenke, Williams and Löwe, 2006):is a seven-item self-report scale, used to identify and measure the severity of generalised anxiety disorder (α=.92). Scores range from 0 to 21, with eight or above distinguishing between clinical and non-clinical populations. Good reliability, criterion, construct, factorial, and procedural validity is reported. Its effectiveness in screening for other common anxiety disorders (panic disorder, social anxiety disorder, and PTSD) has also been established (Spitzer et al 2006).

*Work and Social Adjustment Scale* (WSAS); Mundt, Marks, Greist, and Shear, 2002): is a five-item self-report measure, which assesses functional impairment (α=.70-.94). The scale assesses the impact on work, home, social and private activities, and personal or family relationships.. Scores range from 0-40. A score of above 20 provides indication of severe functional impairment, while scores between 10 and 20 suggest less severe but significant functional impairment. Scores below 10 are considered subclinical. The scale has good reliability and validity (Mundt et al 2002).

**Design**

A comprehensive evaluation was conducted to explore the effectiveness and efficiency of the implementation of 30 months of the @Home eTherapy service. A within-groups design was adopted to compare data collected at the start of treatment to that collected following ‘completion’ of treatment. The study was considered a routine service evaluation. Individual services consented to the data analysis. Clients entering the service consented for their anonymised data to be used in routine evaluations and all data is published on NHS Digital (formerly HSCIC), freely accessible to all, therefore approval from a Research Ethics Committee was not required.

**Data collection and analysis**

Detailed information regarding those who completed two or more treatment appointments between 28th March 2013 and 16th October 2015 was identified. In accordance with IAPT guidelines, discharge following attendance two or more treatment appointments (including appointments coded as ‘assessment and treatment’, ‘treatment’ or ‘review and treatment) constitutes having ‘finished a course of treatment’ (HSCIC, 2016).

This service evaluation uses the standard clinical metrics currently used to evaluate IAPT services nationally (Clarke and Oates 2014). Key to the evaluation of a service is the identification of the number of individuals who recover, reliably improve, and deteriorate during the course of treatment. Individuals with scores above the clinical cut-off on the PHQ9 (>9) and/or GAD7 (>7) at assessment were identified as meeting ‘caseness’ for depression and/or anxiety. First and last scores were used to determine change scores and rates of recovery where individuals moved from caseness on either measure to below caseness on both measures.

The measurement of recovery, however, fails to take into account individuals who may improve to a large extent but do not get below the caseness threshold. Therefore the extent of improvement, regardless of caseness threshold, was also considered. That is, those who have shown reliable improvement. Reliable improvement is identified if there is a decrease in one or both outcome measures that surpasses the measurement error for that measure (PHQ9 ≤ 6; GAD7 ≤ 4) and no increase in the other beyond the error of measurement. On the other hand, if there is an increase in one or both scores that is more than the measurement error, clients are considered to have reliably deteriorated. Rates of reliable recovery, where a client is considered to have both recovered and reliably improved was also calculated.

Data was managed and analysed using SPSS (V22). Descriptive statistics are presented. Inferential statistics are used to assess statistical and clinical significance of change on key measures. Data from the last attended appointment was used.

**RESULTS**

Data pertaining to all clients who were referred to the service initially via all referral sources will be presented. More detailed data will then be presented for the clients who attended two or more treatment appointments with a coordinator and are therefore regarded as having ‘completed’ treatment.

**Data for all referrals**

[INSERT EXTENDED REPORT FIGURE 1]

***Service delivery***

During the 30-month referral period 2054 referrals were received, of those 1355 (66.0%) attended an initial assessment, and 724 (53.4%) attended at least two treatment appointments. A total of 6627 @Home eTherapy telephone support appointments were booked, of which 4714 (71.1%) were attended (of those not attended 471 were DNAs (24.6%), 566 (29.6%) were cancelled by the client and 76 (4.0%) cancelled by the therapist).

**Data for clients who completed treatment**

***Waiting times***

Mean waiting times for a course of treatment, calculated in days from the date of referral to the initial assessment date in all three geographical locations was 18.29 days (SD 11.52). Minimum waiting time was zero days (client offered appointment on day of referral); the maximum waiting time was 92 days. 96.3% of clients started treatment within six weeks and all were seen within 14 weeks.

Table 1 presents the characteristics of these clients who attended two or more appointments over the 30-month time period.

[INSERT EXTENDED REPORT TABLE 1]

The majority of people completing treatment were female (447, 61.7%), aged 45 or under (579, 79.9%) with more than half (413, 57.0%) under 36. Almost all clients reported as being from a ‘White’ ethnic group (660, 91.2%).

***Outcome data analysis***

The following outcome data analysis explores the impact that the @Home eTherapy services had, irrespective of CCBT program accessed.

***Clinical outcome data***

Table 2 presents outcome data for intent to treat analysis for the 724 clients completing at least two treatment appointments.

[INSERT EXTENDED REPORT TABLE 2]

Statistically significant improvements were found on all outcome measures. Large pre to post effect sizes were identified for changes in level of severity of depression, PHQ9 (d=0.98), and anxiety, GAD7 (d=1.07), whilst a medium effect size was identified for functioning, WSAS (d=0.53).

**Caseness**

On intake, 509 (70.3%) met caseness for depression (as defined as a score of 10+ on the PHQ-9) and 598 (82.6%) met caseness for anxiety (as defined as a score of 8+ on GAD-7). 662 met caseness for either depression or anxiety, or both (91.4%), while 62 (8.6%) on initial presentation did not meet caseness for either condition.

**Recovery**

Of those meeting caseness for either depression, anxiety of both at initial presentation, 408 (61.6%) were considered ‘recovered’ at their final appointment by scoring below caseness on both measures.

**Reliable improvement/deterioration**

479 (66.2%) of treated clients met the criteria for reliable improvement from the start to end of treatment and 32 (4.4%) were identified as having reliably deteriorated.

**Reliable recovery**

410 (56.7%) of treated clients met the criteria for reliable recovery.

**Programme accessed and appointments attended**

Not all programmes were available across all sites during the data collection period. As such, given that LLTTF was available throughout the majority of clients were provided access to LLTTF programme (439, 60.6%), smaller number accessed Silvercloud Health (138, 19.1%) and a very small proportion accessed Beating the Blues (32, 4.4%), Sleepio (26, 3.6%) and Breaking Free (1, 0.1%) that became available later on in the data collection period. As such, analysis takes into account all programmes rather than individual programme outcomes. On average 5.6 (SD=2.0) treatment appointments were attended across all offered CCBT programs.

An independent-samples t-test was conducted to compare appointment attendance with moving from caseness to recovery at the last attended session. There was a significant difference between the number of sessions attended for those moving to recovery (M=6.04, SD=1.8) and those still meeting caseness (M=4.62, SD=2.0); t (361)=8.91, p=.00 (two-tailed). The magnitude of the differences in the means (mean difference =1.42, 95% CI: 1.11 to1.73) was large (d = 0.937).

***Benchmarking outcome data***

Following the implementation of IAPT services, annual and monthly reports have been prepared to provide details of activity based on the national IAPT dataset (i.e. HSCIC 2016). The outcomes of the eTherapy service have been considered against this dataset. Where available a direct comparison to CCBT IAPT data is provided (referred to as guided self-help (computer) in HSCIC reports). It will be referred to as guided CBT throughout this report.

While much smaller in terms of numbers accessing, @Home eTherapy service clients were generally comparable in terms of demographics to those accessing IAPT services, with most being from a ‘white’ ethnic group (91%/87%), just under two-thirds being female (62%/ 63%) and similar distribution of referrals over the different age categories.

Table 3 presents data from the second annual report from IAPT services during the 2015/16 reporting year (HSCIC, 2016), acting as a comparison for the data for the eTherapy @Home service.

[INSERT EXTENDED REPORT TABLE 3]

IAPT service data represents individuals who accessed low or high intensity interventions (including CCBT, guided self-help, CBT etc). 96.3% of those finishing a course of treatment waited less than 6 weeks to enter the @Home eTherapy treatment, compared to 91.4% waiting less than 6 weeks within IAPT services nationally (HSCIC 2016). Similar numbers met caseness criteria at therapy intake (91.4% vs 89.9%).

An equivalent number of referrals completed an @Home treatment (53.4%) in comparison to national IAPT service data for individuals receiving a guided CCBT treatment (52.0%). For people accessing CCBT services, @Home service clients attended, on average, almost twice the number of CCBT appointments (5.6) than reported for guided CCBT treatment in national IAPT services (2.9). Recovery and reliable recovery rates exceeded national IAPT service averages and reliable improvement rates were found to be comparable to those identified in IAPT services, however specific guided CCBT data is not available from NHS Digital datasets. In line with recent work exploring the evaluation of evidence-based intervention measurement in routine practice (Delgadillo, McMillan, Leach, Lucock, Gilbody et al 2014) the effect sizes identified for PHQ-9 and GAD-7 data are equivalent to ‘high performance benchmarks’ for national services.

**Discussion**

The aim of the current study was to evaluate outcomes for people with common mental health problems following completion of a CCBT intervention provided as part of an @Home eTherapy service delivered by a third sector organisation. Waiting time targets were met by the service, two thirds of referrals attended at least one appointment with the service, and 35% of referrals completed a course of eTherapy, attending two or more treatment appointments. For clients who completed at least two treatment appointments, the service was associated with significant changes to depression, anxiety and functioning symptoms and treatment effect sizes were large. 91.4% started treatment at caseness, at last appointment 61.6% had recovered, which meets IAPT key performance recovery target of 50% and exceeds national and local IAPT statistics for CCBT services. 410 (56.7%) showed reliable recovery, a figure that surpasses findings from national IAPT services (42.8%). However, it is acknowledged that a direct comparison to those accessing guided CCBT treatment in IAPT is not available.

Rates for completion of treatment (those who completed two or more sessions after commencing guided CCBT treatment) were comparable in comparison to the average performance of national IAPT services (53.4% versus 52.0%; HSCIC, 2016). The completion rate of just over half may reflect the alternative treatment choices available, and as such does not necessarily reflect dissatisfaction with the service. Findings suggested that those who attended more treatment appointments were more likely to move from caseness to recovery, providing rationale to investigate ways to increase engagement or referral strategies for ensuring the needs of individuals who may have more complex presentations and find it difficult to engage. This is in keeping with IAPT service data on the issue of number of sessions and recovery rates. Reliable improvement rates were marginally higher than those found in IAPT services (66.2% compared to 60.8%).

The flexibility of the service, which provides phone support up to 8pm on weekdays, and allows access to the CCBT program 24/7, may have contributed to engagement and outcome. Telephone support is increasingly being offered within IAPT services, but only accounts for 16% of completed treatment, with almost half of those receiving support via a telephone disengaging from treatment after a single appointment (HSCIC 2016). The mean number of contacts for CCBT @Home is similar to IAPT reporting for face-to-face therapies, and approximately twice that reported not just for CCBT, but other low intensity intervention forms. The data suggests that recovery rates may be improved if services focus on retaining clients through a larger number of support appointments. In comparison to previously reported Self Help service data (Cavanagh, et al., 2011), where CCBT support was provided face-to-face, the recovery rates for the @Home eTherapy service are slightly higher (61.6% versus 52.2%), this may reflect a difference in service delivery mode, a general improvement in the service over time, or may be attributed to the type of intervention. Current figures indicate that CCBT is used infrequently by IAPT services with guided CCBT representing only 1.04% of treatment contacts (HSCIC, 2016). However, the benefits from the @Home services identified provide justification of guided CCBT and additionally in offering support in an accessible manner.

***Limitations and future research***

This practice-based evidence evaluated a service in action, the opportunity to conduct a study incorporating controlled conditions could not be implemented. Patient improvement data must therefore be interpreted with caution, as there is the possibility that clients may have fared as well with no treatment. In addition, we know little about the clients who did not engage with the service and subsequently were not considered to have completed treatment. Further evaluation of this sample to establish the sustainability and implementation of the service is warranted.

Analysis involved last observation carried forward, and follow-up data were not analysed, therefore it is unclear if the outcomes were sustained following the last attended appointment and the reasons for discontinuing treatment. Qualitative interviews with clients, particularly those who did not engage at all or dropped out prior to completion of all appointments, to explore the acceptability of the therapy and service, would be valuable. Recent research has highlighted individuals can be negative about using computerised interventions (Musiat, Goldstone, and Tarrier, 2014), which may impact upon the effectiveness of its implementation. However, attendance rates were comparable to national IAPT services offering alternative interventions.

Supported CCBT interventions have two elements – the treatment appointments attended and completion of the different elements of the CCBT program. In terms of engagement, this evaluation focused only on the former. Therefore, clients may attend numerous appointments, but don’t complete any of the program or the reverse. Future evaluations could explore further client engagement with the program alongside telephone support. Furthermore, as an exploration of differences in retention across the different CCBT interventions was not possible we are unable to conclude if outcome is moderated by the different programmes. It is probable, for example, that engagement strategies across the different programmes may differ given the nature of the difficulties that clients are experiencing. Those who access Breaking Free are predominantly affected by dual diagnosis which means that they face additional barriers in engaging with psychological therapy. Those accessing other programmes, however, often present with similar levels of anxiety and depression so more uniform engagement strategies may be effective.

Research should additionally aim to develop more of an understanding about what makes this service achieve the positive impact that it has, if this impact is sustained and why recovery is higher than reported in current IAPT services and non-attendance was less. Understanding more about the ‘active ingredients’ of the service is vital to determine what makes it effective and what lessons can be learnt for implementation. In particular, exploring further the peer support aspect of the delivery model would be beneficial. Directly comparing a CCBT peer supported intervention to the same intervention supported by psychological wellbeing practitioners may provide insight into the impact that such a workforce may have. The way in which the service is implemented and integrated into existing mental health services appears important, and has implications for sustainability; further exploration of implementation models such as exploring the amount of time allocated to clients per co-coordinators in each service delivery model, is warranted. Literature has highlighted the importance of offering guided self-help, rather than pure self-help (i.e. Gellatly et al, 2007). The guided nature of the @Home intervention may therefore play a significant role within the service. Thus, understanding more about the support clients are provided may be important, exploring any differences and similarities to the support provided in IAPT services.

Exploration of who may benefit from the service may also be valuable. Whilst demographically the sample was comparable to national IAPT service user, on the whole individuals of minority groups and those of older ages were underrepresented. Although providing the option of self-referral is reported to allow for more equitable access for different ethnic groups (Clark et al 2009), this was not apparent. While clients could be referred to the services from a number of sources, data regarding the original referral source was not available for all referrals. Previous research has indicated that those who self-refer are likely to require fewer appointments to reach recovery than those who are referred by their GP. This is thought to be as a result of the ability to commence the engagement process with psychological therapy earlier on (Gyani et al, 2011). In addition, while current IAPT service provision focuses predominantly on the delivery of psychological interventions for common mental health problems, there is an identified need to for the establishment of services to fulfil policy requirements for severe mental health problems such as psychosis, bipolar disorder and personality disorders, and beyond the adult population for children and young people, who may be particularly well-suited to eTherapy services. The potential benefit that an eTherapy service could provide to such individuals requires further exploration. Additional issues may be prevalent for individuals accessing CCBT due to the nature and mode of delivery.

**Conclusions**

This service evaluation provides evidence of the benefits associated with the delivery of a third sector @Home eTherapy service that meets the needs of service users by being convenient, non-stigmatising and adaptable to individual time availability, location and pace. This kind of service can address NHS priorities focused on ensuring rapid access to psychological therapies via high accessibility and scalability.

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**Ethical considerations**

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, and its most recent revision.

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