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Experiences and attitudes of primary care therapists in the implementation and use of internet-based treatment in Swedish primary care settings

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ABSTRACT

Background: The current knowledge of internet-based cognitive behavior therapy (ICBT) implemented in primary care settings is sparse. Our *objective* was to explore primary care therapists' experiences and attitudes of ICBT, the opportunities and conditions for research in primary care, and to identify potential barriers to the implementation of ICBT treatment in primary care.
Methods: Eleven therapists (of 14) participating in the research and implementation project PRIM-NET completed a survey. Four of them were selected also for a detailed semi-structured interview. Data from the interviews were analyzed qualitatively and according to methods used in implementation science.
Results: Six general themes were identified in which the therapists considered ICBT as a good treatment that ought to be introduced in primary care. To optimize procedure in primary care settings, several adaptations of ICBT were suggested. Integrating and blending ICBT and face-to-face therapies, for example, would render primary care psychology more efficient. The PRIM-NET study and research within primary care was seen as rewarding and necessary, but challenging. To a large extent primary care still revolves around the general practitioner, with a focus on production, finances, and a somatic aspect of the patients. Five possible *barriers to implementation* of ICBT were identified which perhaps explains why psychological procedures are not fully integrated into primary care.
Conclusions: Although the implementation of new methods and routines is typically accompanied by challenges, the overall experience of the therapists supports the implementation of ICBT as an additional treatment in primary care.
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1. Introduction

Internet-based cognitive behavior therapy (ICBT) may be described as guided self-help interventions where the therapist interaction is asynchronous and the treatment is mainly delivered via websites in the form of text, pictures, and audio file (Andersson and Hedman, 2013). "Defining internet-delivered interventions can however be problematic as there are different conceptualisations and viewpoints" (Andersson, 2009, p.175). For example e-mail therapy, video therapy, and chat therapy (Andersson et al., 2008; Lindefors et al., 2012) make it difficult to refer to ICBT as one clearly defined treatment (Lindefors et al., 2012). Considering current focus on evidence-based treatments, and in light of the positive results from efficacy studies of ICBT for depression (Andersson et al., 2013; Arnberg et al., 2014; Cuijpers et al., 2013; Richards and Richardson, 2012), the introduction and large scale implementation of these techniques in Swedish health care seem imminent. Several programs treating depression with different foci (for example cognitive or behavioral) and setups (for example number of modules, with or without support, and also mode of support) have been used (Andersson et al., 2005; Carlbring et al., 2013; Johansson et al., 2012; Meyer et al., 2009; Perini et al., 2009; Ruwaard et al., 2009; Titov et al., 2011; Warmerdam et al., 2008). However, so far most studies may be characterized as efficacy studies. Also, the effectiveness studies that have been conducted have mostly been performed within second level care and/or in centralized units (Hedman et al., 2014; Hedman et al., 2013; Ruwaard et al., 2012). Also, some studies are performed as open trials without a control group (Newby et al., 2014).

Depression presents a serious condition associated with somatic disorders, a worsened overall health status and an increased risk of morbidity and mortality (Craven and Bland, 2013; Musselman et al., 1998; Pan et al., 2011; Wulsin et al., 1999). It is estimated that about 10% of primary care patients worldwide suffer from clinical depression

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(World Health Organization, 2001). Most cases of depression are identified and treated at primary care level (Bijl and Ravelli, 2000), making it especially relevant to introduce ICBT into primary care context.

When introducing ICBT at primary care centers, the attitudes of the therapists that primarily will be responsible for the implementation and use of ICBT are of course paramount. Nevertheless, there is a paucity of more detailed studies focusing exclusively on ICBT in primary care (Arnberg et al., 2014). Currently little is known of primary care therapists' attitudes towards, and experiences of ICBT. A structured literature search revealed no specific studies on this topic. We have however located reports on psychology students' experiences from training in and using ICBT (Friesen et al., 2014; Hadjistavropoulos et al., 2012), and a Swedish regional report based on attitudes among seven primary care therapists and seven psychiatry therapists using ICBT (Axelsson, 2014). In Axelsson (2014) the therapists viewed ICBT as a valuable complement that could be used in conjunction with face-to-face treatment. According to the therapists, other health care staff had, to some extent, not referred the intended patients but used the ICBT project to offload demanding and severely ill patients. The lack of "flow-through" regarding appropriate patients limits the ability to maintain methodological competence. Axelsson (2014) concludes that a successful introduction and "marketing" of ICBT in health care requires supporting structures on a regional and national level.

Primary care operates in settings and under conditions that in many ways differ from second level or specialized care (Roy-Byrne et al., 2003). In this respect, primary care psychology and primary care therapists need to be cooperative generalists, with knowledge of prevention, behavioral health, developmental psychology, psychopathology, and family issues, based in a systemic, developmental and bio-psychosocial frame of reference of the patient (APA Interorganizational Work Group on Competencies for Primary Care Psychology Practice, 2013). The primary care context is therefore likely to present special challenges that may have an impact on the implementation of new treatment routines and methods. For example, moving from efficacy to effectiveness studies in health care is typically a challenge, which tends to become even more evident in primary care (Roy-Byrne et al., 2003).

The few studies of internet-delivered treatments that have been performed among primary care patients share common experiences of difficulties in the recruitment. Inclusion rates in studies of internet-delivered treatments normally tend to vary between 3% and 25% (Ebert et al., 2015). Clarke et al. (2005) invited a large number of patients identified as suffering from depression (receiving either medication or psychotherapy in the previous 30 days) to ICBT, 2–4% responded. Mead et al. (2005) offered internet-treatment to primary care patients waiting for psychological therapy, one in five responded and the same response rate was found by Whiteside et al. (2014) when primary care patients identified as experiencing a new episode of depression were invited to ICBT. Studies reporting no problems with ICBT treatment in patients referred by general practitioners (GPs) exist (Williams and Andrews, 2013), but have primarily been carried out at a centralized health care unit. These experiences suggest that research-based implementation at primary care can be complicated.

There are several hurdles to overcome for successful dissemination of new programs for treatment. Adherence to evidence-based methods and practice can therefore be lower than might be expected (McFlynn et al., 2003; Seddon et al., 2001). Several frameworks to help understand and guide implementations have been suggested, for example the Seven Barriers to Optimal Care, identified by Cochrane et al. (2007). This framework is condensed from a systematic review of studies in which factors that limited or restricted health care providers to adhere to the implementation of evidence-based clinical practice were identified (see Table 1).

The present study focuses on experiences and attitudes among experienced primary care therapists who participated in the research-based PRIM-NET project aimed at the implementation of ICBT in primary care. The specific aims of the present study are to examine primary care therapists I) attitudes and experiences of ICBT in primary care, II) the conditions and opportunities for research on ICBT in primary care, and III) factors and barriers believed to be important in the implementation of ICBT in primary care.

Table 1
Categories of barriers to optimal care according to Cochrane et al. (2007).

	Barrier category	Barrier description
I	Cognitive-behavioral barriers	Lack of knowledge, awareness, professional skills, or appraisal skills
II	Attitudinal or rational-emotional barriers	Lack of efficacy, lack of confidence, lack of sense of authority, lack of outcome expectancy, lack of accurate self-assessment
III	Health care professional/physician barriers	Influence of invariants such as age, experience, gender, lack of motivation, influence of individual characteristics, concern for legal issues, rigidity of professional boundaries, lack of appropriate peer influences or models
IV	Clinical practice guidelines/evidence barriers	Lack of practical access, lack of comprehensible structure, lack of utility, lack of local applicability, lack of convincing evidence
V	Patient barriers	Conflicting culture; educational, cognitive, attitudinal behaviors; lack of adherent or concordant behavior
VI	Support or resources	Lack of support, lack of human and material resources, lack of financial resources or funding, lack of time
VII	System and process barriers	Lack of organization and structure, lack of harmony with health and oversight systems, lack of referral process, lack of workload-outcome balance, lack of teamwork structure and ethic

2. Method

2.1. Context

During 2010–2013, PRIM-NET (Swedish national research register, FoU — ID number 140531) implemented ICBT for depression at 16 primary care centers throughout the region of Västra Götaland, Sweden, with a total of 14 participating therapists.

At the participating primary care centers, there had to be a therapist trained and experienced in working with CBT and who also agreed to integrate ICBT into their work. PRIM-NET provided all materials needed, including access to the ICBT treatment, information about the project, and education on the specific treatment program, Depressionshjälpen®. The project also provided support via telephone during office hours.

The GPs and the registered nurses (RNs) had a key role at each primary care center. They were instructed to inform and recruit patients who met the basic inclusion criteria of age 18 and older and tentatively identified for depression. Recruited patients were assessed in a semi-structured interview by the primary care center therapist. Eligible patients were randomized to either treatment as usual (TAU) or ICBT. The PRIM-NET project was aimed at mild to moderate depression, defined as less than 35 points at Montgomery Åsberg Depression Rating scale — Self rating version (MADRS-S; Montgomery and Asberg, 1979).

The setup of the ICBT followed a study protocol in which the therapists made a telephone call to the ICBT-patients during the first week to provide support and help patients start the internet-based treatment program. The patients then worked on the internet-package for 8–12 weeks by themselves. Throughout the treatment, they were supported by the same therapist they had met in the initial assessment. The weekly patient–therapist contact was kept mainly via the secure e-mail service, Mina Vårdkontakter (MVK) which is a nationwide and secure communication system between patient and health care provider in Sweden, and by telephone. The therapists were able to monitor the

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