In face-to-face therapy, as with Beating the Blues therapy, this is extremely helpful for people suffering mental distress. To break the mess of confusion they are experiencing into its environmental, physiological, behavioural, cognitive and emotional components helps the person “make sense” of what they are going through.

This CBT explanation is the basis of the first three to four sessions of BtB. The patient is spoken to through voice prompts throughout the session. The program is also interspersed with video vignettes of other patients talking about their situation. The patient is thus similarly helped as a standalone option or in conjunction with face-to-face therapy.

Once a person progresses past the formulation section, the program then offers some activity scheduling, in the mid-sessions followed, in the later sessions, by some in-depth core belief and cognitive restructuring. This work uses terminology that may differ from some CBT current terminology but is nonetheless user-friendly and uses language’s person that can be easily understood. In the funded brief face-to-face therapy sessions that are available it would be rare for a therapist to be able to offer the depth and scope of therapy offered in the later BtB sessions.

Each session takes approximately 50 minutes for patients to complete. You can’t go forward to a new session before completing the previous one. Patients can go back to previous sessions, but to go forward they have to work through the structured program.

Guidelines for GPs enrolling patients in BtB

The Ministry of Health and the BtB national governance group have developed some guidelines for GPs wanting to enrol patients in BtB. These are as follows:

1. As is the case with all contact with health services, a suitably qualified clinician/health professional must be available throughout his or her engagement with the service. In primary care this is usually the GP.

2. In the context of prescribing e-therapy, “suitably qualified health practitioner” is defined as one who is sufficiently qualified and experienced to diagnose and manage anxiety and depression, and other mood disorders. This is defined as a depression PHQ9 (presenting symptoms score of below 15) or a Kessler 10 score of below 30. There is ample evidence in the published research to demonstrate that for depression and anxiety, and other mood disorders, CBT, in combination with an SSRI (selective serotonin reuptake inhibitors) or other antidepressant medication, produces better outcomes than either on its own.

3. Oversight of the patient’s progress throughout the e-therapy process is to be maintained by the patient’s suitably qualified health practitioner (again as in “2” above).

4. Oversight of the patient’s progress throughout the e-therapy process is to be maintained by the patient’s suitably qualified health practitioner (again as in “2” above).

5. “Delegations” enacted to provide these services are to be recorded in the patient’s notes.

6. PHOs or practices will decide which locum staff have authority in respect of the use of e-therapy (patient enrolment plus ongoing oversight), and these staff members will record their involvement in the patient’s notes, as above.

Basically, the program is designed for patients with mild to moderate conditions. This is defined as a depression PHQ9 (patient health questionnaire) score of below 15, or a Kessler 10 score of below 30. There is ample evidence in the published research to demonstrate that for depression and anxiety, and other mood disorders, CBT, in combination with an SSRI (selective serotonin reuptake inhibitors) or other antidepressant medication, produces better outcomes than either on its own.

Once a GP has gone through the mildly time-consuming process (about 15 minutes on average) of enrolling as a BtB provider, the process of enrolling a patient on e-therapy is very quick. Most PHOs have people trained to offer some initial training to GPs and to help them through the process.

Keeping track of patients’ progress

Once the GP is enrolled as a provider, and has enrolled a patient on the program, the benefits become obvious. The GP can track if a patient is improving or deteriorating while on the program. As part of sections 1, 3.5 and 8 the patient completes a PHQ9 and a GAD-7 (generalised anxiety disorder) questionnaire. At these junctures, the patient also completes a suicide screen.

Beating the Blues has a module which alerts GPs to patients with high suicidal ideation. If the patient is having some suicidal thoughts, he or she will be asked about their severity and, if this indicates a risk, will be stopped on the program and a screen will pop up with some helpline contacts. The GP will also receive an email alert advising the patient is at some degree of risk. This issue has caused some concern for GPs who make the assumption this means they will become a pseudo crisis service. This is not the case. The crisis teams for the various PHOs have a statutory responsibility to monitor risk, and if the GP has not given the patient these contact numbers it may be incumbent on the GP to do so at this point.

www.beatingtheblues.co.nz – program structure

Patient views a short outline introduction video on Beating the Blues.

Goal setting for therapy. Explains how thoughts can affect feelings. First behavioural module: problem solving or activity scheduling (according to specific individual problems).

Teaches about unhelpful thoughts. Demonstrates how to check thoughts for thinking errors.

Examines the way the patient attributes reasons to events in their lives. Identifies links between the reasons attributed and effects on patients’ self-esteem.

Explain how depression and anxiety can affect a person physically, emotionally, behaviourally and cognitively.

Teaches about inner beliefs and how they can contribute to depression and/or anxiety. The patient verifies whether his/her “inner belief” is helpful or unhelpful.

Exams the patient’s explanations for the good and bad things that happen to him/her.

Explain how and when to check thoughts for thinking errors.}

Beating the Blues or BtB (which is free in New Zealand) is a cognitive behavioural therapy (CBT) based-e-therapy program. It is a comparatively expensive, structured program of eight sessions in which a person must be enrolled by being given a “blue prescription”. But BtB is currently being funded by the Ministry of Health and made available to all GPs and other qualified clinicians through Manage My Health (www.managemyhealth.co.nz).

Doctors have to register themselves, after which they can issue patients with blue prescriptions which will allow them to access and undertake the BtB program.

A UK trial, conducted by Judy Proudfoot and colleagues, used a randomised control comparison of patients who had treatment as usual (TAU) with a group who had BtB only.2 They found those who had received BtB showed significantly greater improvements in depression and anxiety compared with the TAU group by the end of treatment (two months) and at the six-month follow up.

Symptom reduction was paralleled by improvements both in social and work adjustment. Overall, the team’s findings indicated this mode of therapy may have wide applicability in general practice. It could be offered either as an adjunct to pharmacotherapy or to those patients who refuse drugs. Furthermore, the results indicate the effects of BtB are independent of the baseline level of depression. BtB was as effective with mild depression as with severe depression.

The BtB Programme – how it works

Beating the Blues is an eight-session program and begins with the five-part CBT model that formulates and conceptualises the mood disorder (not just depression, but anxiety, adjustment disorder, grief and any other mild to moderate condition).
Those who complete BtB report astounding results

As stated, BtB uptake shows similarities to trends in prescribing medication for depression. Many people don’t get their prescription filled, ie, they don’t activate it. Many people also don’t complete the course, ie, they stop when they feel good again. A few people quit and even fewer have suicidal thoughts while on the course. This is the nature of mood disorders. However, those who do complete BtB report astounding results. Those who don’t either deteriorate or they get better and move on, and you don’t hear from them again.

The ministry’s rollout of BtB is halfway through its initial trial. To have a previously expensive program freely available to GPs to prescribe to their patients represents a great addition to the armoury of medication for depression. Many people don’t get their prescription filled, ie, they don’t activate it. Many people also don’t complete the course, ie, they stop when they feel good again. A few people quit and even fewer have suicidal thoughts while on the course. This is the nature of mood disorders. However, those who do complete BtB report astounding results. Those who don’t either deteriorate or they get better and move on, and you don’t hear from them again.