MasterMind

Deliverable D3.1

Scientific Study Protocol

MASTERMIND
"MAnagement of mental health diSorders Through advancEd technologyand seRvices – telehealth for the MIND"
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D3.1 Scientific Trial Protocol

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EXECUTIVE SUMMARY

Computerised Cognitive Behavioural Therapies (cCBT) and collaborative care facilitated by videoconferencing (ccVC) in treating patients with depression are likely to be clinical and cost effective. Additionally, these interventions are ideally suited to enlarge healthcare services' reach and access. However, up scaling into routine practice is lagging behind.

The MasterMind project aims to implement and upscale cCBT and ccVC in routine practice and targets to reach over 5,230 patients and 118 professionals in routine care in 11 different European regions in 15 different implementation projects. The effectiveness of these implementation projects will be evaluated with the objective to identify the factors that promote or inhibit implementation and up scaling of cCBT and ccVC for treating depression in routine practice. This document describes the generic study protocol. The study runs for a total of 36 months.

For MasterMind, a multi-level and mixed-methods evaluation will be undertaken using a process and pre-test-post-test study design. The evaluation will assess the viewpoints of three levels of stakeholders involved in the implementation projects: 1) patients, 2) healthcare professionals and 3) mental healthcare organisations. A mixed-methods approach will be employed which can provide a good understanding of what (quantitative results) the implementation projects have achieved, and how or why (qualitative results) these outcomes occurred. Using qualitative methods of data collection can also provide a good insight into unintended consequences, and will provide lessons for improvement of both interventions and the implementation and up scaling of future interventions in routine practice.

The evaluation is structured according to the Model for ASessment of Telemedicine (MAST) in which seven highly interrelated domains will be assessed: 1) client and care profiles, 2) safety of patients, 3) clinical change in depressive symptoms, 4) implementation related costs, 5) patient and professional perspectives towards cCBT and ccVC, 6) organisational aspects and the broader 7) social, legal and ethical issues related to employing cCBT and ccVC in routine practice. Transferability will be assessed in two steps: first experienced regions will implement cCBT in routine practice; the lessons learned from this first implementation wave will be employed by less experienced regions in a second wave.

Routine practice is our laboratory, thus the measurements should not interfere with the object of our study. Therefore, the study outcomes will be based on data already available in routine care, such as information on the reduction of depressive symptoms. In addition, short self-report questionnaires will be used to measure satisfaction with and usability of cCBT and ccVC as this information is not available in routine focus group interviews with a limited group of healthcare professionals; structured interviews with representatives from the involved healthcare organisations will be undertaken to gain a better understanding of the process that leads to implementation success or failure.

Outcomes will be:

- reach of the interventions,
- perceived acceptability by patients and healthcare professionals of cCBT and ccVC, and
- perceived appropriateness of cCBT and ccVC to address patients' and healthcare professionals' needs.

Additionally:

- implementation costs; and
- intended sustained use of the interventions in routine practice by the organisation;

will be considered as well.

The resulting summative evaluation will provide valuable insight into the factors that influence the implementation and up-scaling of cCBT and ccVC in a variety of real political, social, economic and clinical contexts. It will provide insight into the perspectives of involved stakeholders, and result in concrete recommendations for implementing and up-scaling cCBT and ccVC for depression in different mental healthcare contexts.

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1. Introduction

1.1 Purpose of this document

This document describes the generic study protocol for evaluating the implementation projects in the MasterMind project. It addresses the:

- Study objectives.
- Study design.
- Evaluation methodology including the operationalisation of the study objectives into measurable items.
- Measurements and instruments.
- Outcomes.
- A framework for analysis.
- Data collection procedures and data quality assurance.
- Information on the implementation projects including the intervention, technical platform used and contact details.

The generic study protocol sets the minimum requirements for implementation projects and provides the basis for the generic codebook. All implementation sites will translate and tailor the generic study protocol to a local study protocol.

1.2 Glossary

cCBT	Computerised Cognitive Behaviour Therapy
ccVC	Collaborative care facilitated by Video Conferencing
DSM IV	Diagnostic and Statistical Manual of Mental Disorders – Fourth edition
DoW	Description of Work, contractual obligations of MasterMind consortium. Also known as the Technical Annex to the Grant Agreement.
GP	General Practitioner
MAST	Model for ASsessment of Telemedicine applications
MDD	Major Depressive Disorder
RCT	Randomised Controlled Trial
ROM	Routine Outcome Measurement
SC	Scientific Committee

2. Background

2.1 Depression as health problem and depression treatment

Unipolar depression is amongst the most prevalent mental disorders around the world, and is associated with a high disease burden and elevated economic and societal costs due to absenteeism, early retirement, loss of productivity and premature death (Ferrari et al., 2013; Kessler, 2007; Wittchen et al., 2011). Annual estimated costs of depression are 177 and 147 million Euro per 1 million inhabitants for major and minor depression respectively (Smit, Cuijpers, Oostenbrink, & Batelaan, 2006). In addition, depression is characterised by an early onset; it is associated with high chronicity, low quality of life, impaired social and personal relationships, disturbed academic and professional life, and a variety of physical health problems (Barney, Griffiths, Jorm, & Christensen, 2006; Titov, 2011). According to the World Health Organisation (WHO) depression is the largest single cause of disability worldwide, accounting for 11% of all years lived with disability globally (World Health Organisation, 2013).

The adverse impact of depression on individuals and society underline the need for the provision of effective psychological therapies. Nevertheless, the number of people that receive treatment for depressive disorders are considerably low (Andrews, Henderson, & Hall, 2001; Spijker, Bijl, De Graaf, & Nolen, 2001). Among the barriers to psychotherapy are the high costs of participating in sessions with a professional psychotherapist, the stigma associated with the participation in a psychological intervention, the limited number of trained clinicians, and the limited access to low threshold, low cost and evidence based psychotherapy (Barney et al., 2006; Titov, 2011).

The majority of persons with a mild or moderate depressive disorder receive treatment in primary care settings, mostly by GPs, by means of antidepressants and less by brief psychotherapeutic interventions. Patients suffering from more severe depressive disorders are often referred to specialised mental health care services where treatment consists of medication, psychotherapy or a combination of both (Cuijpers et al., 2012; Cuijpers, van Straten, Andersson, & van Oppen, 2008b; Wittchen et al., 2011). For specialised care, there is an overall trend in Europe to replace inpatient by outpatient care in specialised mental health centres, and treat depression if appropriate in the community in primary care settings. However, the rates differ considerably between EU countries.

2.2 Computerised cognitive behavioural therapy for depression

In general, current interventions (i.e. treatments) for depression are designed to relieve symptoms, restore damaged and core functions and prevent relapse. The most common evidence based interventions are psychotherapy and pharmacotherapy. MasterMind focuses on psychotherapy which can be in either a face-to-face format, contained in book format (bibliotherapy), or electronic format (internet-based treatment) with some kind of personal support from a therapist (Cuijpers et al., 2008b).

Cognitive Behavioural Therapy (CBT) is one of the most studied psychotherapies, and has been found to be an effective treatment for depressive symptoms. The basic assumption of CBT is that depression is perpetuated by maladaptive thoughts that could be modified into

adaptive thoughts and thus lead to changes in behaviour, which ultimately results in less depressive symptoms.

CBT consists of highly structured therapeutic sessions focusing on cognitive input and behavioural change. Therefore, CBT is ideally suited for information technology based administration. For example, the instructions to reach therapy goals can be easily transmitted by technological means including homework assignments for the patient.

Several Randomized Controlled Trials (RCT) and meta-analyses have examined the effectiveness of Internet and other computerised CBT programmes for the reduction of depressive symptoms. The results so far have shown that Internet based CBT is effective in treating depressive complaints (Andersson & Cuijpers, 2009; Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Cuijpers, van Straten, & Andersson, 2008a; Gallego & Emmelkamp, 2012; Hedman et al., 2014; Spek et al., 2007; Warmerdam, van Straten, Twisk, Riper, & Cuijpers, 2008) and even as effective or more effective than pharmacological treatments for certain populations (Cuijpers et al., 2012; Roshanaei Moghaddam et al., 2011). Pharmacological treatment combined with psychotherapy is suggested to yield even more effect in reducing the clinical burden of depression (Cuijpers, 2014). Also, studies on cost-effectiveness show that cCBT in depressed patients is a promising solution (Gerhards et al., 2010; Hollinghurst et al., 2010; Warmerdam, Smit, van Straten, Riper, & Cuijpers, 2010). Because certain therapeutic elements of the therapy can be automated, the therapist can focus on those parts of the treatment that depend on the client-therapist intervention, and to treat more patients at the same time. Therefore, cCBT appears to be a promising approach in alleviating the burden of depression.

2.3 Collaborative care for depression facilitated by video conferencing

Collaborative care is associated with significant improvement in for example depression and anxiety outcomes compared with usual care, and represents a useful addition to clinical pathways for adult patients with depression and anxiety (Archer et al., 2012). For MasterMind, collaborative care is to be understood as care consisting of: a multi-professional approach to patient care, structured management plan, scheduled patient follow-ups, and enhanced inter-professional communication (Gunn, Diggens, Hegarty, & Blashki, 2006).

Use of videoconference technologies in psychiatry has been shown to be a viable option for delivering mental healthcare to patients, both in inpatient and in outpatient settings (Shore, 2013; Valdagno, Goracci, di Volo, & Fagiolini, 2014). Besides delivering specific treatments (e.g. anger management), previous research has demonstrated that using videoconferencing-facilitated mental healthcare services is satisfactory for patients, improves health outcomes, and might be cost effective (Richardson 2009 et al.). However, there is also a need for awareness of the salient regulatory, administrative and clinical issues that may arise in the practice of modern telepsychiatry (Shore, 2013).

Collaborative care facilitated by videoconferencing has been shown to be as effective as or more effective than practice-based collaborative care for patients who screened positive for depression (Fortney et al., 2007). Similarly, research suggests that telemedicine-based collaborative care does not increase total workload for primary care or mental health providers (Fortney, Maciejewski, Tripathi, Deen, & Pyne, 2011).

2.4 Implementation in routine practice

With these major achievements in mind, increasingly more emphasis and effort is put into testing and applying evidence-based interventions in real life pilots and care settings. Several good examples of successful implementation of evidence-based interventions in routine practice exist. However, it seems that implementation and up-scaling of evidence based interventions often take place in research and pilot projects and hence have a limited scale and effect in reducing the actual disease burden of mental disorders in daily practice (Barlow, Bullis, Comer, & Ametaj, 2013; Emmelkamp et al., 2013; Kazdin & Blase, 2011; McHugh & Barlow, 2010; 2012).

Reasons for the low uptake of evidence-based interventions by routine practice are until now only partly understood. Suggestions differ, and include reasons such as that it might have to do with the strong comorbidity among psychological disorders requiring more complex treatment and care than ICT-based interventions might be able to offer, the (relative) insensitivities to interpersonal differences in patients, or the relative (in)applicability of knowledge obtained by nomothetic driven RCTs in relation to helping the personal patient characteristics, and the dodo bird interpretation of psychological therapies and limited therapist allegiance to clinical guidelines. Other than that, issues with the structure of healthcare delivery system including financial incentives and reimbursement systems, lack of adequately trained professionals and workforce instability, professionals' standing and attitudes to innovation, and client perspectives to their health and care, might be influencing the uptake and sustainability of evidence-based therapies in routine practice.

This translational problem of scientific knowledge to daily practice is not new, and is not limited to health sciences alone (see e.g. Rogers, 2003). However, a field of research emerged that pushes forward promising suggestions on how to change this situation. Endeavours in this field of Implementation Science range from theoretical explorations like the Normalisation Process Theory by May and Finch (May & Finch, 2009), to a magnitude of concepts, frameworks and models charting the factors influencing the dissemination and translation of knowledge to practice such as Greenhalgh and colleague's model for diffusion of innovations in health service organisations (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004), and the Consolidated Framework for Implementation Research by (Damschroder et al., 2009), to more pragmatic approaches such as the MAST assessment framework developed by Kidholm and colleagues (Kidholm et al., 2012) and Glasgow's RE-AIM framework enabling the planning and evaluation of concrete implementation programmes in practice (Glasgow, Vogt, & Boles, 1999).

Taken together, the huge burden depression places on people and societies, the availability of evidence-based and feasible interventions, and the novel insights brought forward in the field of Implementation Science, provides both the urgency and opportunity for conducting practice-oriented research on implementing and up-scaling evidence based interventions in routine mental healthcare. With this in mind, the present study intends to provide insight into the aspects that might influence the uptake of computerised Cognitive Behavioural Therapy (cCBT) services by the mental healthcare community in 11 different European regions, and to provide the community with strategies for implementing cCBT in different healthcare contexts.

3. Study Objectives

The MasterMind Consortium intends to implement and up-scale evidence-based[1] computerised Cognitive Behavioural Therapy (cCBT) services for depressed adults across a number of EU and Associated Countries, and from this implementation: a) identify barriers and success factors to implement cCBT on a large scale and b) to recommend successful strategies for implementing cCBT in different contexts. Additionally, MasterMind aims to implement video-conference-enabled collaborative care (ccVC) for patients who are treated for depression. Using the lessons learnt, the Consortium will develop guidelines and a tool kit for promoting and facilitating the broader implementation across Europe of a safe, effective and efficient service that is supported by relevant stakeholders.

For these purposes, the present study pursues the following seven objectives:

1. To identify the factors which promote or hinder the implementation of cCBT and ccVC for treating depression in routine practice.
2. To assess change of patients' depressive symptoms when treated with cCBT and ccVC in routine practice.
3. To assess the costs associated with implementation and large-scale uptake of cCBT and ccVC for treating depression in routine practice.
4. To assess patients' safety in terms of their mental health when provided with cCBT and ccVC in routine practice.
5. To assess the perceived satisfaction and perceived usability of cCBT and ccVC in:
   - Patients when treated for depression;
   - Healthcare professionals when treating patients suffering from depression;
   - Healthcare professionals when using ccVC in a collaborative care setting.
6. To identify the reach of cCBT and ccVC in routine practice through assessing general patient characteristics.
7. To identify how to implement cCBT and ccVC at a large scale in routine practice in different care contexts.

[1] We adhere to the American Psychological Association Policy Statement on Evidence-Based Practice in Psychology stating: "Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." (American Psychological Association, 2006).

4. Study design

To reach the study objectives, the MasterMind Consortium engages in 15 implementation projects in which evidence-based cCBT and ccVC will be implemented and up-scaled in routine mental healthcare practice in 11 European regions.

Within this *implementation study*, we defined implementation success as a function of reach, clinical effectiveness, acceptability and appropriateness, and sustainability (Proctor et al., 2011). Reach is the participation rate and representativeness of patients at an individual level (Glasgow, 2007). Clinical effectiveness is to be understood in terms of the change in clinical symptoms associated with depression during treatment according to routine care in which the programme is implemented. Acceptability and appropriateness respectively refer to the perception among stakeholders that the treatment is satisfactory and perceived fit in addressing the mental disorder (Proctor et al., 2011). Sustainability or maintenance is the extent to which the sustained use of the intervention in routine practice is arranged for (Proctor et al., 2011). Routine mental healthcare practice is meant the care usually delivered to clients when they are diagnosed with depression. Depending on the diagnosis and care system, patients in MasterMind can be treated in primary care or in specialised care settings. Specialised mental healthcare entails both outpatient and inpatient care settings. Implementation is defined as the active and planned efforts to mainstream an innovation within an organisation (Greenhalgh et al., 2004). Implementation at scale refers to 15 implementation projects in 11 different European regions; at least 5.230 patients with depression will receive treatment.

The cCBT interventions included in the implementation projects are evidence-based in that there is consistent scientific evidence suggesting that the underlying therapeutic principles can improve health related client outcomes. In this sense, we adhere to the American Psychological Association Policy Statement on Evidence-Based Practice in Psychology stating: “Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.”(American Psychological Association, 2006).

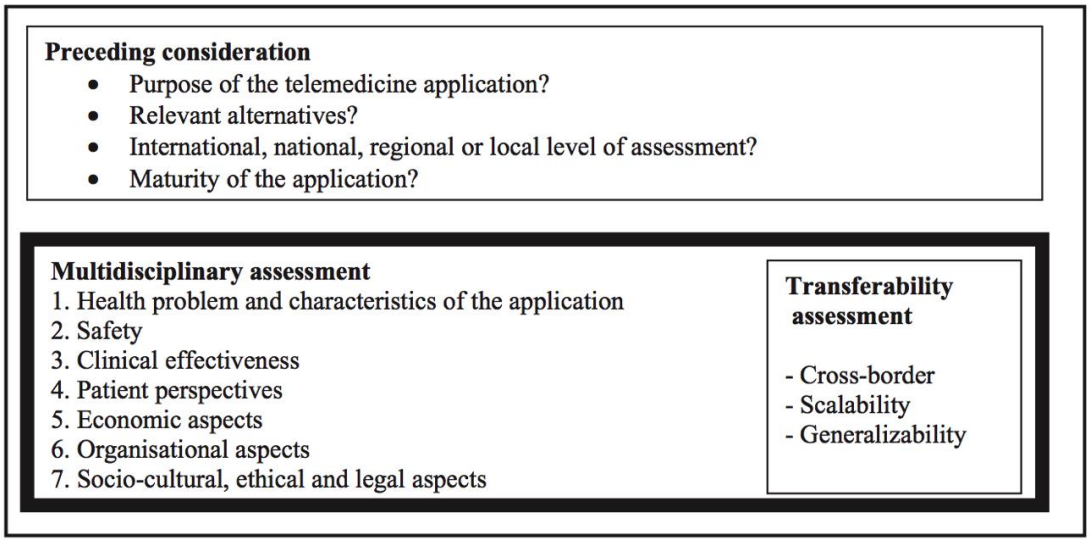
For analysis, a mixed-methods observational evaluation will be undertaken using a one-group pretest-posttest study design (Campbell & Stanley, 1963). The evaluation will assess three levels of stakeholders involved in the implementation projects by assessing the viewpoints of patients, healthcare professionals and involved mental healthcare organisations. The interactions between these three levels are of interest as they influence each other, and their contexts in terms of e.g. how different organisational settings moderate individual behaviour and their (adoption) decision-making and the impact of different organisational structures and cultures on the decisions of particular groups and individuals (e.g. openness of therapists in large v. small practices) (Greenhalgh et al., 2004). A mixed-methods approach will be employed because it can provide a good understanding of what (quantitative results) the implementation projects have achieved, and how or why (qualitative results) these outcomes occurred (Palinkas et al., 2011). Using qualitative methods of data collection can also provide a good insight into unintended consequences and lessons for improvement of both interventions and the implementation and up-scaling of future interventions in routine practice.

The evaluation is structured according to the validated Multidisciplinary assessment provided by the MAST framework (Kidholm et al., 2012) that is tailored to achieving the specific study objectives.

4.1 MAST

The evaluation of MasterMind has been designed in accordance with the validated Model for ASsessment of Telemedicine applications (MAST) (Kidholm et al., 2012). MAST provides a systematic and multidisciplinary assessment of the impact of the integrated telemedicine services such as cCBT and ccVC. The overall framework is founded on a broad view and analysis of the factors and areas to consider and account for when introducing and implementing telemedicine in an existing healthcare setting.

The principal elements of MAST are outlined in the figure below. In the first step of an assessment. a number of preceding considerations is made, e.g. regarding legislation, reimbursement and maturity of the application. Thereafter, a multidisciplinary assessment is carried out including assessment of outcomes divided into a number of domains, including safety, clinical effectiveness, patient perspectives and economic, organisational and broader societal aspects. Finally, assessment is made of the transferability of the results to help institutions or hospitals in different contexts and regions in Europe to learn from the results.



4.2 Protocol development

The development of the study protocol is lead by VU University Amsterdam, the Netherlands, in collaboration with GGZ InGeest, the Netherlands, and Health Information Management S.A., Belgium. All MasterMind partners co-developed, provided their input and critically reviewed the relevance and feasibility of the study objectives, study design, operationalised indicators, measurements and instruments. Data managers of all trial sites discussed and acknowledged feasibility in terms of either the availability of data in existing databases, or obtaining and administrating data via questionnaires and interviews.

For the operationalisation, first the project's mission, objectives and expected results were translated into verifiable study objectives (section 3). Based on requirements set by the DoW and MAST, a suitable but pragmatic study design was chosen (section 4). With the study design in mind, and based on relevant literature, the objectives were operationalised into relevant concepts, dimensions and finally measurable indicators, including their definitions. The operationalisation is based on RE-AIM (Glasgow et al., 1999), the Normalisation Process Theory (NPT) (May & Finch, 2009), and the measurement instrument for determinants of innovations (MIDI) (Fleuren, Paulussen, Van Dommelen, & Van Buuren, 2014). Where possible, validated instruments will be used to perform the measurements.

4.3 Scientific Committee

The aim of the Scientific Committee (SC) is to ensure a high homogeneity between the implementing sites and high quality of the data and subsequent analysis. The SC does so by advising on the elaboration of the design and analysis of the evaluation study. For the respective seven domains of MAST, an expert is appointed for the duration of the project so each MasterMind partner can be advised in conducting the trial and applying the MAST framework. WP3 leader chairs the SC. The members are:

Name	Position, Affiliation	Expertise	MAST domain
Dr. Jose María Quintana	Head of the Research Unit Medical Section Galdakao Hospital - Usansolo and associate professor in the Department of Preventive Medicine and Public Health, University of the Basque Country UPV / EHU	Epidemiology, preventive medicine, public health policy and management	4. Patient perspectives and professional
Dr. Anne-Kirstine Dyrvig	Department for Research and HTA at Odense University Hospital (PhD in 2013)	(mini)-HTA, transferability, public health	Transferability
Davor Mucic, MD	MD, psychiatrist, director of the centre at The Little Prince Psychiatric Centre; chair telemental health section at EPA	Telepsychiatric treatment across cultures	1. Health problem and application; 4. Patient and professional perspectives
Prof. Kevin Power	Honorary Professor Psychology, University of Sterling, UK; Area head NHS Tayside Psychological Therapies Service, Scotland. National Assessor	Adult mental health services, evaluating treatments for anxiety disorders.	1. Health problem and application; 3. Clinical eff. 4. Patient and professional perspectives
Dr. Judith Bosmans	Assistant professor at department of Health Sciences at the faculty of Life Sciences of the VU University Amsterdam	Economic evaluations, epidemiology, life sciences	5. Cost-effectiveness

Name	Position, Affiliation	Expertise	MAST domain
Mr. Frank Schalken (to be confirmed)	Initiator and director of E-hulp.nl, a Dutch independent foundation that stimulates and develops online counselling and therapy.	Implementation of online care and quality improvement	6. Organisational aspects; 7. Socio, ethical and legal aspects; Transferability

5. The implementation projects

The implementation projects for cCBT are grouped into two separate waves. Wave one includes regions that are experienced in providing cCBT and/or ccVC, either in (research) controlled environments or in smaller scale. Wave two concerns those regions who have no or limited knowledge of and experience with cCBT and ccVC, and thus need to adapt and localise the available cCBT and ccVC solutions to their specific needs and context. Lessons learnt by wave one regions will be shared with wave two regions. The projects implementing ccVC run in parallel to the cCBT waves. The table below gives an overview of the participating countries and organisations, and their distribution over the two study waves for cCBT and ccVC.

Country	1st wave cCBT	2nd wave cCBT	ccVC	Primary care, and outpatient clinic	Secondary care	Regions / partners
Denmark	X		X	X		RSD
Scotland	X			X		NHS24
Netherlands	X		X	X	X	GGZ InGeest VU University Amsterdam
Germany	X		X	X		Schoen Clinic Friedrich-Alexander University
Norway	X		X	X		Norwegian Centre for Integrated Care and Telemedicine
Wales		X	X	X		Powys Health Board Institute of Rural Health
Spain		X X X X	X X X X		X	Aragon (Servicio Aragones de Salud) Basque Country (Kronikgune & Osakidetza) BSA (Badalona Serveis Assistencials SA) Galicia (Servizo Galego de Saúde – SERGAS)
Italy		X X	X X		X	Veneto (U.L.S.S. 9) CSI Piedmont Azienda Sanitaria Locale Torino 3
Turkey		X			X	Middle East Technical University (METU)
Estonia		X			X	Tallinn University of Technology
Greenland			X	X		Agency for Health and Prevention
Total	**5**	**9**	**12**			

5.1 Description of the interventions for cCBT

Different cCBT applications have been created worldwide by public and private entities. The MasterMind study makes use both of applications that are available for some years (MoodGym and Beating the Blues) and of more recent developments that could have advantages by integrating full video and audio support and more intuitive and user friendly designs (e.g. I-KAT, Get On Mood Enhancer).

The following tables provide an overview of the interventions and their integrations at the first wave implementation sites. The cCBT solutions presented below have been presented to the MasterMind consortium at a dedicated Marketplace event on 25th June 2014 in Amsterdam, NL. At the end of the table, a preliminary overview of the interventions and platforms that will be used by the second wave partners are listed.

iKAT-D	
Origin and development	Developed by the Danish Agency for Digitisation. It is inspired by the Swedish Karolinska cCBT model (Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institute, Stockholm, Sweden).
Vendor / Company	Context Consulting - www.context.dk
Applying region or partner	Region Syddanmark, Denmark, Department of Psychiatry - Internetpsykiatrien - Odense University.
Usage	• Self referral via Internet. • Admission by video-assessment of candidates performed by psychologists. • 10-week treatment with written online support by psychologists. Continuous communication possibility with supporting psychologists.
cCBT package	Internet based cCBT-program consisting of six mandatory and two optional modules. The six mandatory modules are entitled “Introduction”, “Registering Activities”, “Planning Activities”, “Negative Automatic Thoughts”, “Challenging Negative Automatic Thoughts” and "Relapse Prevention". Two optional modules, “Intermediate Beliefs” and “Rumination”.
Technical requirements	• Internet access at home. • PC or tablet; any browser. • Webcam / microphone (for initial assessment only).
Advantages	Based on HTML5. Suitable for all modern web browsers. Modern intuitive, clear and user-friendly interface.
Scientific reference	• General cCBT literature. • (Hedman et al., 2014) • Being a recent development, there are no specific publications on iKAT-D so far.
Get.ON Mood Enhancer / MindDistrict	
Origin and development	Developed by Leuphana University Luneburg in collaboration with the VU University Amsterdam and MindDistrict with financial support of the European Regional Development Fund. Intellectual property is held by Leuphana University.
Vendor / Company	MindDistrict - www.minddistrict.com
1st wave usage	Schoen Clinic, Germany.

Usage at 1st wave site	Nationwide use by eight psychiatry clinics. Self-referral and referral by cooperation with health insurance companies and advertising in professional journals and on the Schoen Clinic website followed by an online assessment and by a personal interview. Non-responders will be offered face-to-face CBT.
cCBT package	Internet based guided cCBT program consisting of seven modules: "Psychoeducation", "Behavioural Activation I", "Behavioural Activation II", "Problem-Solving I", "Problem-Solving II", "Relapse Prevention", "Booster Session". Individual feedback by a guiding psychologist after each module via integrated messaging and video consultation. Integrated monitoring and reporting, depression diary.
Technical requirements	• Internet access at home. • PC, browser with JavaScript. • Full video and audio support.
Advantages	The MindDistrict platform represents a flexible Content Management System specifically built for online psychotherapy. New content can be created; questionnaires and screening tools can be easily adapted to the requirements and indicators of the MasterMind trial and also for other CBT indications besides depression. No programming skills required when creating or adapting specific treatment courses. Complimentary mobile applications are in development and will be available shortly.
Scientific reference	• General cCBT literature. • (Ebert et al., 2014)
MindDistrict application implemented by GGZ inGeest and VU University Amsterdam	
Origin and development	Developed by GGZ inGeest and VU University Amsterdam.
Vendor / Company	MindDistrict - www.minddistrict.com
1st wave usage	GGZ inGeest, Netherlands.
Usage at 1st wave site	cCBT is part of a blended treatment offered by the regional mental health organisation GGZ inGeest in both basic and specialised mental health care settings. Admission is integrated in blended care after referral by a GP. In specialised settings, 10 face-to-face sessions are alternated with 10 online CBT sessions during a 10-14 weeks course. In basic mental health care, there will be a higher number of online sessions.
cCBT package	Guided Internet-based CBT comprising seven modules entitled "Monitoring and getting insight", "Motivation and goal setting", "Activation: monitoring", "Activation: Day Structure", "Cognitive restructuring", "G-Scheme (thoughts)", "Relapse prevention".
Technical requirements	• Internet access. • PC and browser with JavaScript. • Full video and audio support.
Advantages	The MindDistrict platform represents a flexible Content Management System specifically built for online psychotherapy, which at GGZ inGeest allowed easy setup of a blended care version of cCBT. No programming skills are required when creating or adapting specific treatment courses.
Scientific reference	General cCBT literature.

MoodGym	
Origin and development	Developed by the Australian National University and translated to Norwegian by the Dept. of Psychology UIT, The Norwegian Arctic University. See: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3636015/.
Vendor / Company	Australian National University.
1st wave usage	Norwegian Centre for Integrated care and Telemedicine.
Usage at 1st wave site	Self-referral, referral by GPs and referral from waiting lists plus formal assessment (Becks Inventory of Depression). Part of a newly designed integrated care model comprising self-care, primary healthcare and specialist healthcare. Integrated video support (GP to specialist, between specialists).
cCBT package	Unguided Internet-based cCBT-program consisting of five modules and a personal workbook. Modules are entitled “Feelings”, “Thoughts”, “Unwarping”, “De-Stressing”, “Relationships”. Depression and anxiety quiz at the end of each modules. Approximately five-week course, 45 to 60 minutes to complete each module. Further information at www.moodgym.anu.edu.au.
Technical requirements	• Internet access at home. • PC browser, JavaScript, Flash.
Advantages	Longstanding experience. 750.000 registered users. Free to use, no licence required.
Scientific reference	• General cCBT literature. • (Hoifodt et al., 2013) The PhD thesis of Ove Lindtvedt gives a comprehensive sum up of our present knowledge http://hdl.handle.net/10037/5483.
Beating the Blues	
Origin and development	Developed by the Institute of Psychiatry at Kings College London. The most widely used cCBT application in the UK.
Vendor / Company	Ultrasis - www.ultrasisplc.com
1st wave usage	National Health Service Scotland NHS24.
Usage at 1st wave site	Admission by the psychology service of four Scottish NHS health boards as one of the first treatment options of a stepped care model. No self-referral. Standardised monitoring of progress and suicide risk by dedicated personnel, suicide alerts linked to clinical intervention.
cCBT package	Unguided Internet-based cCBT consisting of eight modules of approximately 60 minutes duration each. The modules include instructions about unhelpful thoughts and inner beliefs, and address problem solving and activity scheduling, graded exposure, task breakdown, sleep management with a final review of learned items and goal setting for the months after treatment completion. Further information at www.beatingtheblues.co.uk.
Technical requirements	• Internet access at home. Also offered in different community locations (libraries, community centres). • PC browser, JavaScript, Flash.
Advantages	Longstanding experience in the UK. Good evidence base.

Scientific reference	• General cCBT literature. • (Proudfoot et al., 2004) • Recommendations by the UK National Institute for Health and Care Excellence and by the Scottish Intercollegiate Guidelines Network.
Second wave platforms	
• Wales: Beating the Blues (see above). • Treviso: iFightDepression. • Piedmont: iFightDepression. • Estonia: iFight depression. • Turkey: TOP SENDE, which is based on the Dutch intervention 'Alles onder controle' developed by the VUA. It is localised to the Turkish situation and culture. • Aragón, Galicia, Badalona and Basque Country: have adapted existing clinical contents into a common set of modules that will be used in a multi-site approach. The cCBT programme contains eight modules supported by videos in order to facilitate understanding by the patients. • In addition, Badalona has decided to also join the Spanish cluster to deploy a common intervention within the country.	

5.2 Description of the interventions for ccVC

As indicated above, collaborative care assisted by videoconferencing in MasterMind aims to create a closer link between healthcare providers (highly specialised level of care and generalist care) for the delivery of treatment, care, and learning. Further, the project aims to assess clinical pathways for the use of collaborative care facilitated by VC. Many mental healthcare organisations in Europe have already invested in VC equipment and infrastructure.

Using the Cochrane definition of collaborative care (Gunn et al., 2006), the ccVC services in MasterMind will be primarily utilised as a guiding and monitoring tool during treatment for a mental disorder, or to facilitate shared decision making between psychiatric specialist care and GPs. Scotland, Estonia and Turkey will not deploy ccVC, whereas Greenland will realise a collaborative care model based exclusively on the use of videoconferencing. The table below provides an overview of the various ccVC applications implemented in MasterMind.

Partner	Description
NST	NST intends to integrate cCBT and ccVC as part of a holistic, stepped care integrated system for diagnosis and treatment of mental and psychosocial problems in a limited setting area of Northern Norway. ccVC will be used from specialist to GP with the patient. Acute videoconferencing from GP on-call to specialist will also be used.
BSA	The ccVC will be used at the BSA's primary care centres to improve GPs communication with specialists (psychiatrists) at the hospital. At BSA, GPs will deal with patients impaired by mild and moderate depression, while the specialists deal with patients experiencing more severe symptoms of depression. GPs will be able to schedule visits with the patient and with the psychiatrist where both the GP and the specialist must be available. The idea is that the specialist deals with the situation while the GP is learning.

Partner	Description
RSD	RSD are planning to use ccVC between care manager and patients. They will use ccVC to give support and CBT via videoconferencing system. The ccVC will be of the Cisco Jabber type.
AHP	AHP will use Microsoft Lync and Skype based video consultations between patients and practitioner in Nuuk. There will be a weekly “open hotline” where local clinics can contact the ward to discuss ad-hoc issues. Scheduled consultations between patients and carer will be booked and held regularly during the week. The tele-psychiatric services will be offered to all patient groups, not just depressed.
ULSS N. 9	In order to improve assessment, diagnosis and therapy for clients, ULSS N. 9 will use ccVC for better communication between GP and psychiatrist and psychologist. ULSS N.9 will also use ccVC to discuss and agree about patient's needs in the different places of discontinuity of the organisation (i.e. acute ward and community service and GP and psychiatrists).
Schön Klinik	There will be a combination of outpatient treatment provided by videoconference and cCBT elements. Two patient groups will be targeted with the treatment: clients in rural areas as an alternative to face-to-face psychotherapy, and inpatients who do not have an outpatient treatment following inpatient treatment as an alternative to outpatient psychotherapy. The patient is at home using his own computer anywhere in Germany while the therapist is a clinic employee in Bad Arolsen. The sessions will be regular outpatient CBT care, with the only difference that client and therapist are not in the same room, and that the client can also use cCBT sessions, mainly as "homework".
GGZ inGeest	inGeest will incorporate videoconferencing in the cCBT treatment protocol. The use of videoconferencing will replace some face-to-face sessions in order to further lower the (cost) thresholds for treatment.
PHB	Videoconference will facilitate communication between GP and specialist in order to ensure the best outcome for patients with more complex or perplexing needs within the identified limits of mild to moderate depression. It may or may not involve the patient in the surgery.
ASL TO3	Videoconference will be made available for GPs, so that they will be able to get online support from specialists, with or without the patients, as needed. The same equipment will be made available at patients’ homes as well, to allow patients to get in touch with the doctors when needed (e.g. to monitor the treatment, as well as to monitor the cCBT course, if the patient is also receiving it). Lastly, the equipment will be made available for both acute and post-acute care.
Osakidetza	The Basque Country has decided to use the first modality of video, collaborative care between GP and specialist. GPs and specialists will organise regular videoconferences to analyse and discuss complex case management, a non face-to-face clinical session. In addition, the GP will be able to contact the specialist by videoconference in order to ask specific questions or resolve doubts, so his/her decision making capacity increases. On the other hand, specialist will contact the GP sporadically when he/she needs a general overview of the patient´s health status or social context.

Partner	Description
SERGAS	At first SERGAS will use of videoconference as collaborative care between specialist and GP; if this was accepted by their professionals, they would use videoconference as collaborative care between specialist and GP with patient too when it is necessary.
SALUD	SALUD wants to facilitate interaction between GPs and specialists from the mental care area. The main goal of these teleconsultation activities will be to give support, feedback and training to the GPs, especially in the health centres located in remote areas. Videoconference will also be used to complement the cCBT implementation project at different stages, for tele-advice or tele-consultation for diagnosis and follow-up.

5.3 Participant enrolment

Population, number of participants and referral modalities

For the study, three levels of participants are distinguished: patients, healthcare professionals, and mental healthcare organisations. The table below provides the target number of participants for each implementation site for which quota sampling is applied.

	Patients	Healthcare professionals	Organisations
Syddanmark (DK)	800	16	23
Scotland (UK)	800	16	1
Wales (UK)	500	10	9
GGZ InGeest Amsterdam Area (NL)	300	6	4
Aragon (ES)	100	2	1
Basque Country (ES)	300	6	3
Badalonas Serv. Assist. (ES)	200	4	1
Galicia (ES)	200	4	1
Veneto (IT)	200	20	1
Piedmont (IT)	300	6	1
Turkey (TR)	200	3	1
Hessen (DE)	500	10	1
North. Norway (NO)	500	30	16
Estonia (EE)	300	6	1
Greenland (GL)	30	2	1
TOTAL	**5230**	**141**	**65**

Patients' enrolment

Adult patients from routine mental healthcare practices at the involved implementation sites will be offered cCBT, and will be invited to participate in the study when they have symptoms of mild, moderate or severe depression. Depression symptoms will be established by the procedures as practised in the routine care practices of participating implementation sites. For those sites implementing ccVC, inclusion in the evaluation study is defined as when the patient commences treatment. Termination is defined as six months after inclusion.

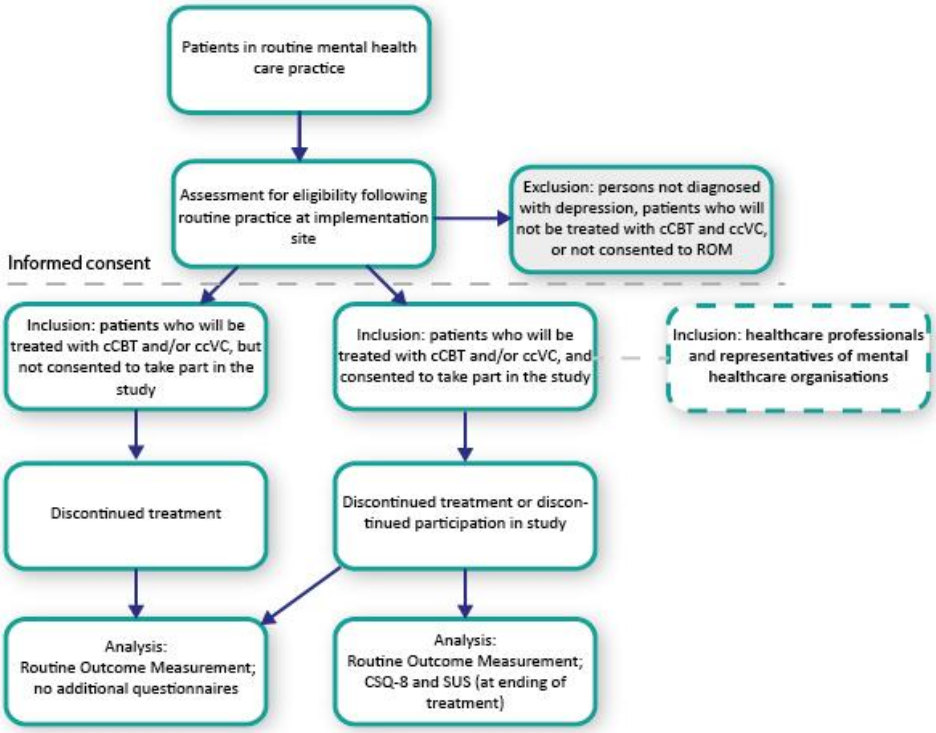
From the studies' viewpoint and at the time of enrolment, there are three categories of patients:

a) patients who do not want to receive cCBT treatment,

b) patients who are willing to receive cCBT, and

c) those who receive cCBT, perform ROM and agree to participate in additional questionnaires.

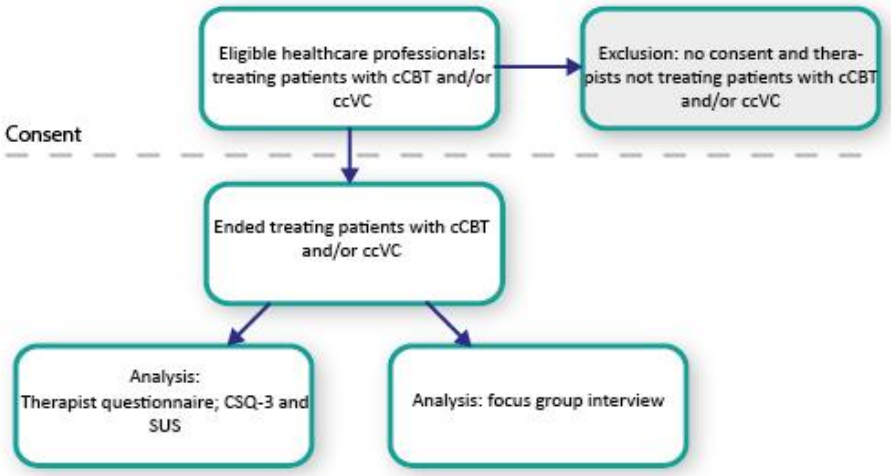
This is reflected in the following flow diagram.



Agreeing patients will receive cCBT treatment. In case a patient and the healthcare professional decide to apply cCBT and/or ccVC, and if they will perform Routine Outcome Measurements (ROM), the ROM data will be included in the analysis. Additionally, the patient can consent to partake in additional questionnaires.

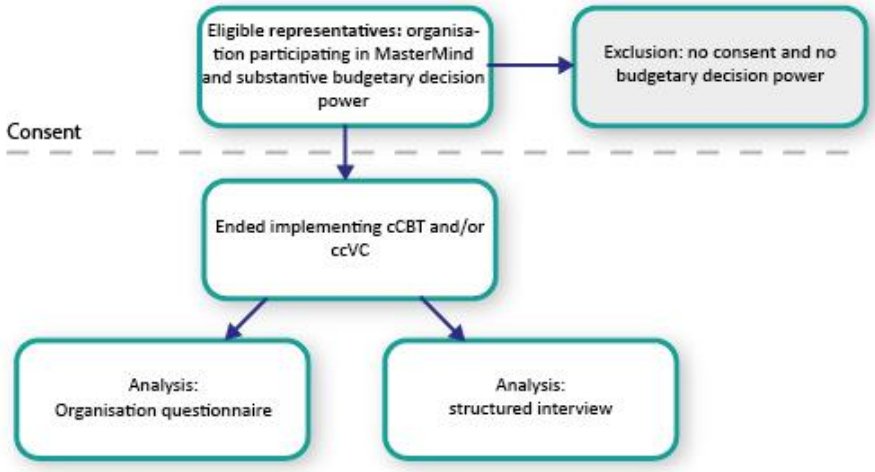
Enrolment of healthcare professionals

In MasterMind, healthcare professionals are mental healthcare workers who are trained to provide patients with cCBT and/or to refer patients to cCBT. Healthcare professionals can be therapists and referrers. We choose this broad definition because of the heterogeneity in Europe in treating mental disorders, and because it allows assessing transferability of the findings in different contexts and healthcare settings. In this study, healthcare professionals vary from GPs to psychiatrists and psychologists. Healthcare professionals are included in MasterMind if they treat a depressed patient with cCBT during the inclusion period, and if they consent to partake in the study. This implies that healthcare professionals have received training or are experienced in cCBT and/or ccVC, either previously or through MasterMind prior to the inclusion period. These criteria hold for partaking in the evaluation of the implementation of both cCBT and ccVC. The figure below provides an overview of the healthcare professional enrolment in and flows through the study.



Enrolment of mental healthcare organisations

For the MasterMind project, mental healthcare organisations are defined as the service providers that implement the cCBT interventions in their routine practice. As routine practice varies for each implementation site, the organisations involved also vary, from GP practices to large specialised care centres. For each involved healthcare provider, a representative will be invited to partake in the study. To be included in the study, the representative should have substantive decision power related to the management of their organisation's mental healthcare practice. The figure below provides an overview of the mental healthcare organisation enrolment in the study.



Start- and end dates of the implementation projects

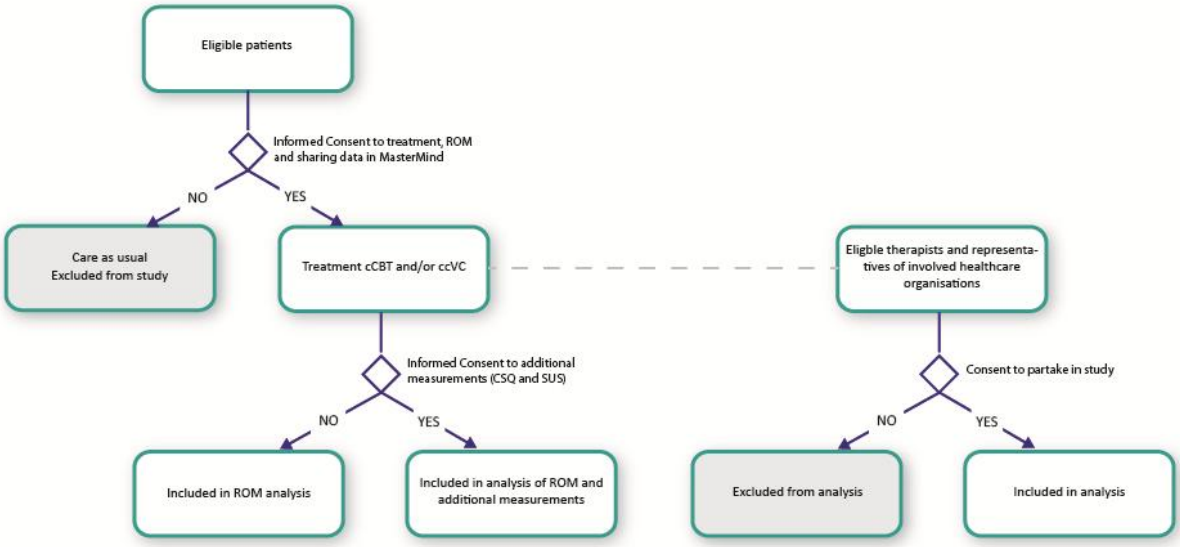
Wave-one projects start the 1st January 2015 and end on 31st December 2016. Wave-two implementation projects are anticipated to start the 1st October 2015 and run also until 31st December 2016. Sites implementing ccVC will commence from the 1st January 2015 until 31st December 2016.

Individual treatment duration

The exact treatment modalities depend on the type and structure of the cCBT platform used, the individual needs of patients, and the actual care setting (see section 0). For minimal requirements, patients using cCBT that have completed at least three therapeutic modules will be considered as completers. For ccVC, commencement of treatment is defined at inclusion; termination is at maximum six months after commencement.

Informed consent

Although the MasterMind study is about evaluating implementation of cCBT and ccVC in routine practice, and thus not on sharing clinical data as is done in experimental research, the MasterMind consortium will inform participants that their anonymised data may be shared for evaluation of the service. As such, patients, healthcare professionals and representatives of involved healthcare organisations need to consent to taking part in the study. Each potential participant will have sufficient time to consider their participation, after having been informed about the protocol and possible questions will be have been answered. The figure below provides an overview of the type of informed consent required.



Withdrawal of treatment or study

After providing consent, participants can withdraw from or stop the study at any time without explanation or consequences, but still receive treatment. Participants who no longer wish to take part in the study have to contact their healthcare professional or the local study coordinator, usually by email or telephone, who will follow-up on the reason for dropping out of the study if the participant is willing to share this information. As all data will be anonymised, requesting removal of personal data is not relevant.

Equally, patients can withdraw from or stop the treatment at any time without explanation or consequences. In case of urgent medical reasons, such as suicidal ideation, the healthcare professional can decide to withdraw a participant from the treatment. Patients can also prematurely dropout of different parts of the treatment and remain in other parts or modules according to routine practices. Healthcare professionals should register when a

patient does not commit to the proposed treatment plan (e.g. by not completing online sessions) or terminates (parts of) the treatment, and, if known, the reason for stopping.

Ethics and quality assurance

Ethical approval for conducting this study will be obtained in each participating country in conformity with existing local clinical guidelines and local legislation. Please see D2.1 Ethics Plan and Ethical Checklist for more information.

Ethical standards and guidelines will be applied in line with the latest version of the declaration of Helsinki. More specifically, all included institutions, researchers and healthcare professionals will follow the European Good Clinical Practice Directive (2001/20/EC), the charter of fundamental rights of the EU (2000/C 364/01), the directive 95/46/EC (amendment 2003) of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the protection of privacy, storing of personal data and on the free movement of such data, the Directive 95/46/EC on the protection of individuals with regard to processing of personal data and on the free movement of such data and the Council Directive 83/570/EEC of 26 October 1983 amending Directives 65/65/EEC, 75/318/EEC and 75/319/EEC on the approximation laid down by law, regulation, or administrative action relating to proprietary medicinal products. Each trial will be registered in a local clinical trial register.

Each participating institution will follow all the relevant legal acts of the participating countries and all of the relevant EU legislation on data protection. The procedures for the collection and storage of personal data will be conducting in alignment with the relevant European Regulations and Directives, in particular with Directive 1995/46/CE on data protection, 1997/66/CE on the handling of personal information and Directive 2002/58/CE (on the same subject). In order to ensure data confidentiality, participants' personal information / clinical records will be locked in the institution allowing only authorised healthcare professionals and researchers to have access. Sharing data between participating countries will follow the regulations of each host country. In order to protect all information, all partners will follow all the relevant AES (Advanced Encryption Standard) procedures for personal password use and data encryption. Electronic data will be password protected and will be accessed only by authorised personnel.

Safety and stopping rules

As the study follows routine practice, the risk of physical or psychological harm for participants due to participation in this study is expected to be low. Any serious adverse event (SAE) (regardless of their possible relationship to the study) or any unexpected problem that endangers the physical or mental health of the patients, such as suicidal ideation, will be handled in accordance with the regulations specified by routine practice. Additionally, the trial sites inform the MasterMind management team in case of a SAE as well.

6. Evaluation

6.1 Introduction

For good implementation research, it is an imperative to not interfere with the implementation processes, as this might lead to distorted picture of reality (Proctor et al., 2009). Therefore, the present study and its measurements are designed to connect as much as possible to existing data within the offered treatments and service providers, and to keep the burden on patients, healthcare professionals and service providers in obtaining information as low as possible. This is achieved in different ways.

First and foremost, data will be collected from the Routine Outcome Measurements (ROM). Secondly, data will be collected through the intervention platforms. Thirdly, an online questionnaire will be incorporated in or connected to the intervention platforms to obtain additional patient and healthcare professional data. Fourth, focus group interviews will be conducted with a representative sample of healthcare professionals at all implementation sites. Fifth, representatives of the participating mental healthcare organisations will be questioned both through a questionnaire, and using a structured interview script.

First an overview is given of the indicators for each study objective, including their instruments for measurement. Secondly, the measurements are given in section 6.3, including instruments, the expected time burden, and time points. Finally, in section 6.4 and 6.5, the study outcomes are presented and data analysis is discussed. In Appendices A & B, the operationalisation of the dimensions towards indicators can be found, including their definition and measurement for each MAST domain and for both cCBT and ccVC.

6.2 Overview of the MAST dimensions of indicators per objective

The table below provides an overview of the objectives and related MAST domains and the instruments for measurements.

Study objective	Relevant MAST domains*	Instrument
1) To identify barriers and facilitators that influences the implementation of cCBT and ccVC for treating depression in routine practice.	All domains.	ROM, Treatment platform, questionnaire, structured interview, focus-group interview
2) To assess clinical change of patients' depressive symptoms when treated with cCBT and ccVC in routine practice.	Domain 3: Clinical effectiveness.	ROM, Treatment platform, MANSA Questionnaire
3) To assess the costs associated with implementing and large-scale uptake of cCBT and ccVC for treating depression in routine practice.	Domain 5: Economic aspects. Domain 6: Organisational aspects.	Questionnaire, structured interview

Study objective	Relevant MAST domains*	Instrument
4) To assess patients' safety in terms of their health when provided with cCBT and ccVC in routine practice.	Domain 2: Safety.	ROM, Technical platform, Questionnaire
5) To assess the perceived satisfaction and perceived usability with cCBT and ccVC of: a) patients when treated for depression. b) healthcare professionals when treating patients suffering from depression; c) healthcare professionals when using ccVC in a collaborative care setting.	Domain 4: Patient and healthcare professional perspectives. Domain 6: Organisational aspects. Domain 7: Socio, ethical and legal aspects.	For satisfaction: CSQ-8 (patient) and CSQ-3 (healthcare professional) For usability: SUS
6) To assess who receives cCBT and ccVC in routine practice.	Domain 1: Health problem and general characteristics.	ROM, Technical platform, Questionnaire
7) To assess the transferability of implementation and up scaling of cCBT and ccVC in routine practice in different care contexts.	All domains.	ROM, Treatment platform, questionnaire, structured interview, focus-group interview

* See Appendices A & B for the operationalisation of the indicators including the dimensions, definitions, instruments and time points.

6.3 Measurements

All questionnaire measures will be conducted online in local language. When no translation is available of a validated questionnaire, it will be translated by the local implementation teams following the forwards-backwards method, i.e. the questionnaire will first be translated from English into the local language by two persons who will reach consensus by discussion. In addition, the questionnaire will be translated back to English and is compared with the original questionnaire. The focus-group interviews with the healthcare professionals will be conducted face-to-face. The structured interviews with the representative of the participating mental healthcare providers will be conducted either face-to-face or by telephone or voice-over-IP services. Both the focus-group interviews and the structured interviews will be conducted in local language. Preceding the focus-group interviews and structured interviews, participants will be asked to fill out a short questionnaire to obtain general information about the interviewees and to prepare them for the interviews. Local interviewers will be provided with elaborate interview guides including tips for interview techniques as well as elaborate questions. The tables below provide an overview of the measures and their time of assessment.

Patient level

Dimension	Instrument	Time burden	Base line	End of treatment	End of study
Demographics Patient	ROM	±15 minutes depending on routine practice	X		
Patient safety	ROM		X (and ROM)	X	
Depressive symptoms	ROM		X (and ROM)	X	
Quality of life	MANSA	1 minutes	X (and ROM)	X	
Treatment access	Questionnaire	1 minutes		X	
Drop-out	Technical platform / questionnaire	2 minutes	X	X	
Patient perceived satisfaction	CSQ-8*	3 minutes		X	
Patient perceived usability	SUS*	3 minutes		X	

* Adapted to specific context

Healthcare professional level

Dimension	Instrument	Time Burdon	Base line	End of treatment	End of study
Demographics Healthcare professional	Questionnaire	3 minutes	X		
Professional experience	Questionnaire		X		
Healthcare professional case load	Questionnaire	2 minutes	X		X
Healthcare professional perceived satisfaction	CSQ-3*	1 minute			X
Healthcare professional perceived usability	SUS*	3 minutes			X
Perceived patient safety by healthcare professional	Focus-group interview	Maximum 60 minutes			X
Perspective on drop-out	Focus-group interview				X
Leadership engagement (commitment)	Focus-group interview				X
Resources (time)	Focus-group interview				X
Knowledge and beliefs about intervention	Focus-group interview				X
Self efficacy	Focus-group interview				X
State of change	Focus-group interview				X
Identification with organisation	Focus-group interview				X
Support	Focus-group interview				X
Rewards	Focus-group interview				X
Priority	Focus-group interview				X
Professional liability	Focus-group interview				X

* Adapted to specific context

Organisational level

Dimension	Instrument	Time Burdon	Base line	End of treatment	End of study
Implementation costs	Questionnaire	Maximum 10 minutes			X
Operational costs	Questionnaire				X
Demographics organisation	Questionnaire				X
Maintenance	Structured interview				X
Implementation strategy	Structured interview	Maximum 30 minutes			X
Perspective on implementation	Structured interview				X
Guidelines	Structured interview				X
Public image / benchmarking	Structured interview				X

6.4 Outcomes

In literature, implementation outcomes are defined as the effects of deliberate and purposive actions to implement new treatments, practices, and services (Proctor et al., 2011). For this evaluation study, the primary outcome measure is implementation effectiveness. Outcomes will be measured at three levels: 1) the patient, 2) the healthcare professional and 3) the mental healthcare organisation. In light of the study objectives, implementation effectiveness is approached differently for each of these three levels.

Patient level

Patient level outcomes are reach, acceptability and appropriateness of the treatment in alleviating depressive symptoms. Reach is the participation rate and representativeness of patients at an individual level (Glasgow, 2007). It provides valuable insight into the uptake of cCBT in real world settings. Reach will be calculated by dividing the number of patients that received cCBT within MasterMind (extrapolated to the number of patients normally treated in local routine practice in the same period), by the number of people in the general population that are eligible to receive treatment for depression. Acceptability is the perception among patients that the received treatment is agreeable, palatable, or satisfactory (Proctor et al., 2011). Appropriateness is the perceived fit, relevance, or compatibility of the treatment for the patient in addressing his or her mental disorder (Proctor et al., 2011). Acceptability and appropriateness will be measured through:

a) establishing change in depressive symptoms and quality of life;
b) establishing perceived satisfaction with the treatment;
c) establishing the perceived usability of the treatment; and
d) treatment attrition.

The method for measuring the symptoms of depression will adhere to routine practice and will be registered in terms of: clinical interview, professional clinical judgement, or a symptom questionnaire. Symptoms are recorded in terms of no, mild, moderate and severe symptoms according to routine practice diagnostic procedures using appropriate transformation scales if needed.

Quality of life will be measured using an adapted version of the Manchester Short Assessment of Quality of Life (MANSA) (Priebe, Huxley, Knight, & Evans, 1999). The questionnaire used consists of two questions about patients' satisfaction with their health in general and their mental health specifically. The MANSA showed satisfactory psychometric properties (Björkman & Svensson, 2005).

Patient Satisfaction will be measured with the eight item Client Satisfaction Questionnaire (CSQ-8) (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). CSQ-8 is a Likert scale with eight items and a very brief instrument to investigate client satisfaction with the delivered services. It has good psychometric properties, and it has been tested in numerous studies on diverse client samples (Attkisson & Zwick, 1982).

Usability will be measured with the System Usability Scale (SUS) (Brooke, 1996). SUS is a 10-item Likert scale and a brief instrument to measure perceived system usability. It is proven to have good psychometric properties and is tested in numerous studies (Brooke, 2013; Lewis & Sauro, 2009).

Attrition is the phenomenon of participants stopping to use the treatment and/or being lost to follow-up (Eysenbach, 2005). Attrition will be measured by dropout rates, the number of online therapeutic sessions ended successfully.

Healthcare professional level

Healthcare professional level outcomes are acceptability and appropriateness of the interventions in terms of:

a) perceived satisfaction with the intervention as a whole; and
b) perceived usability of the treatment in their daily work.

Satisfaction will be measured with the three items Client Satisfaction Questionnaire (CSQ-3) (Larsen et al., 1979) (see above). Usability will be measured with the System Usability Scale (SUS) (Brooke, 1996) (see above). Additionally, specific focus group discussions will be held with involved healthcare professionals on the following topics:

- Safety issues related to using cCBT.
- Reasons for dropout of patients from the intervention.
- Organisational aspects such as leadership engagement, implementation strategies, resources for innovation, attitude towards the interventions, perceived innovation climate, et cetera.
- Socio, ethical and legal aspects such as guidelines and professional liability.

Organisation level

The organisation level outcomes are implementation costs and sustainability of the intervention in routine care.

Implementation costs are defined as the cost impact of an implementation effort (Proctor et al., 2011). For this study, the actual cost for implementing the intervention will be estimated.

Maintenance (or sustainability) is the extent to which the sustained use of the intervention in routine practice is arranged for. Sustainability concerns the extent to which the

implemented treatment is maintained or institutionalised within a mental healthcare organisation's on-going, stable operations. Maintenance involves longer-term effects and is associated with organisation's funding strategies (Proctor et al., 2011). As such, maintenance will be measured in terms of the intended sustained use of the intervention by the organisation.

Both implementation costs and the intended maintenance of the intervention in routine practice will be measured through several structured interviews with representatives of the involved mental healthcare organisations covering issues such as perceived success of implementation projects, and the presence (or absence) and contents of specific funding strategies for sustaining the intervention in daily practice.

6.5 Data analysis

Data collected will be analysed for each site and level (patient, healthcare professional and organisation) separately, and subsequently pooled for a combined aggregated analysis. Analysis will be of a summative nature combining quantitative data with qualitative data (Caracelli & Greene, 1993; Gaglio & E Glasgow, 2012).

At patient level, data of all participants will be included in the statistical analysis when they are eligible and agree to receiving treatment, regardless of whether the participant ends their participation as intended. The reason for this is that information on e.g. complete discontinuation of treatment or parts of the treatment provide valuable information on the effectiveness of the implementation programme. As the focus of this study is on implementation effectiveness, no data, or parts of the data missing, is core information to the outcomes as well. Therefore, no imputation techniques will be applied. Data from healthcare professionals and representatives of the healthcare providers will be included in the analysis when the participants provide their consent. The analysis consists of three steps:

- Step 1: The three levels of patient-healthcare professional-organisation are assumed to be hierarchical and interdependent issuing covariance. Therefore, the data will be approached using amongst others multilevel (implementation site) repeated measures regression techniques. Univariate analysis will be used to investigate demographic and clinical variables associated with adherence.
- Step 2: Through *thematic analysis,* semantic units of meaning related to the study objectives will be identified inductively within the qualitative data, and then coded and included with the quantitative data in statistical analysis (Braun & Clarke, 2006).
- Step 3: Analysis on combined data will be of a descriptive nature in order to preserve heterogeneity between levels and contexts of sites. This will be done by using *narrative summaries* in the form of simple descriptions and tables of disaggregated data (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005). Additionally, advanced statistical methods will be employed to investigate cross-sectional relationships between levels (patients, healthcare professionals and organisations), care settings and, if possible, specific intervention characteristics.

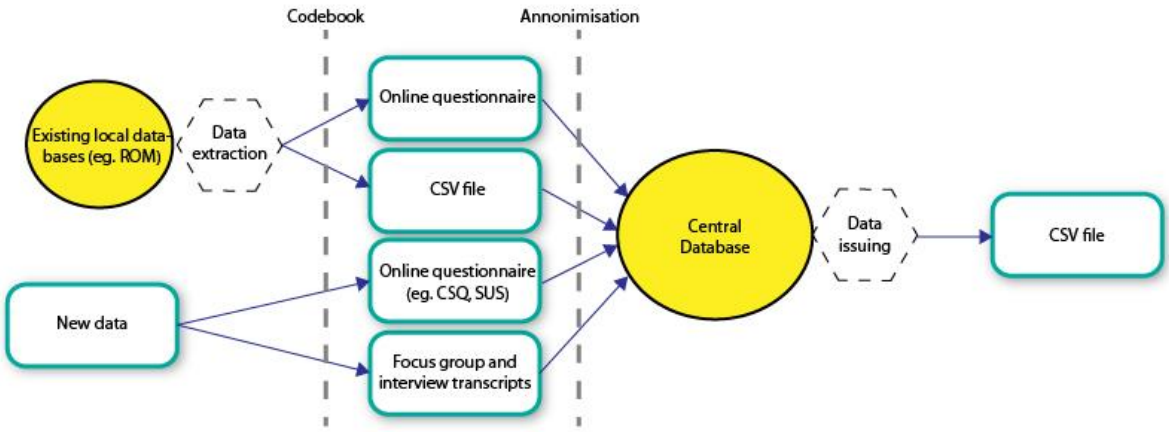
7. Data management

7.1 Data collection

Existing and relevant data in routine practice will be used as much as possible. When no data is available, or it is unreasonably difficult to obtain, new data will be collected through online questionnaires, focus group discussions and structured interviews. Three subsequent steps can be distinguished in the data collection process:

a) data collection at local level;
b) uploading to the central database; and
c) issuing data for analytic purposes for both national and European perspectives.

Throughout the data collection process, several measures will be undertaken to ensure a high level and standardised data set (see below). The figure below depicts the data collection process.



Following the generic codebook, the implementation sites will upload their data to the central database by using two different methods:

a) a secured online questionnaires; or
b) uploading CSV files in a secure section in Arsenàl.IT web portal.

The data will be anonymous, in that patients will not be identifiable through the data in the central database. The data collection procedure will follow the codebook that is based on the generic study protocols and the indicators listed in Appendices A & B. All implementation sites appoint a data manager who will be in charge of uploading the local data to the central database and assuring adherence to the codebook. All data uploaded to the central database will be in English. Local implementation sites are responsible for the translations.

7.2 Data storage and security

All assessments will be held in confidence. Study data will be stored in local data management systems at each trial site. Data will be aggregated for reporting purposes. Data transferred to the central database will be encrypted and anonymised. Participants (patients, healthcare professionals and representatives of the organisations) will be assigned an ID number; identifiable information will be kept separate from the data. Only the local research teams will have access to both databases. Data will be stored for at least five years after publication of research. Specific data sharing agreements, including appropriate measures for data issuing, will be arranged prior to uploading data to the central database.

7.3 Data quality

A high level and consistent data quality is ensured by two measures: a) a codebook for all implementation sites, and b) local field guides for collecting the data.

The codebook is based on the operationalised list of indicators (see Appendices A & B). It provides the structure and layout of the data files, and will include:

- definitions of concepts and the record types;
- response codes for each variable;
- measures to indicate non-response and missing data;
- the exact questions and skip patterns used in the questionnaires (if applicable).

The local field guide is a document that explains in more depth the meaning and interpretation of the concepts, questions, and methods to obtain the local data. The local field guide will be based on the generic protocol (see Appendix J). It will provide the local data managers, data collectors and interviewers a practical guide to obtaining the data in a standardised manner. It will e.g. provide specific information for interviewers on techniques and methods for focus group discussions and structured interviews.

8. Presentation of results

Results of the study will be presented following the MAST framework at both local and central level:

- The health problem and characteristics of the application, including the reach.
- Safety aspects.
- Clinical change.
- Patient and healthcare professional perspectives regarding satisfaction and usability.
- Economic aspects.
- Organisational aspects.
- Socio-cultural, ethical and legal aspects.

For each of these domains, the barriers and facilitators will be identified, as well as the transferability of results to different contexts and care settings. Additionally, the conclusions will be related to existing evidence on effectiveness and known facilitators and barriers for large-scale implementation.

The results and reports will be made available to relevant stakeholders through the project website and scientific publications. Additionally, the results will be actively disseminated to stakeholders following the dissemination plan (see deliverable D2.1 Dissemination Plan for more detailed information).

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Appendix A: Indicators and measurements for cCBT

A.1 Domain 1: Health problem and general characteristics: patient and healthcare professional profiles (cCBT)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Patient demographics	1	Age	The length of time a person lived	What is the patient's age?	Number of years from birth	Data extraction query or questionnaire	Patient	Pre-treatment
	2	Gender	Main category based on reproductive function	What is the patient's gender?	1=Male; 2=Female	Data extraction query or questionnaire	Patient	Pre-treatment
	3	Education	Highest level of completed education	What is the highest level of education the patient received and completed?	1=Primary; 2=Secondary; 3=Higher and/or University; 4=Other	Data extraction query or questionnaire	Patient	Pre-treatment
	4	Immigration	Ancestry of the patient	Has the patient or one of his/hers parents immigrated to the country he/she now resides?	1=Yes; 2=No; 3=ancestry or NA	Data extraction query or questionnaire	Patient	Pre-treatment
	5	Residency	Current main place of living.	What is the postal code the patient currently resides in?	Postal code	Data extraction query or questionnaire	Patient	Pre-treatment
	6	Employment	Employment	Are you currently employed?	1=Yes; 2=No; 3=Not applicable	Data extraction query or questionnaire	Patient	Pre-treatment
Healthcare professional demographics	7	Gender	Main category based on reproductive function	What is the gender of the healthcare professional providing or referring the treatment?	1=Male; 2=Female	Questionnaire	Healthcare professional	Pre-treatment
Professional experience	8	Profession	The healthcare professional's profession	What is the official profession of the healthcare professional providing the treatment?	1=GP; 2=Licensed psychologist; 3=Psychologist in training under supervision; 4=Psychologist with completed basic training; 5=Psychiatrist; 6=Psychiatrist with informal training in CBT; 7=psychiatrist with a diploma in CBT; 8=psychiatrist with a master; 9=psychiatrist with a doctorate; 10=Mental health worker or community location staff; 11=Central administrator; 12=Other	Questionnaire	Healthcare professional	Pre-treatment
	9	Field experience	The number of years the healthcare professional has experience in mental health care	In years, how much experience has the healthcare professional in mental health care?	1=less than 3 years; 2=3 years or more but less than 5 years; 3=5 years or more, but less than 10 years; 4=10 years or more	Questionnaire	Healthcare professional	Pre-treatment

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	10	cCBT experience	Experience in CBT	How many times did the healthcare professional provide a patient with cCBT or refer a patient to cCBT?	1=0-4 times, 2=5-9 times, 3=10-14 times, 4=15-19 times; 5=more than 20 times	Questionnaire	Healthcare professional	Pre-treatment
	11	Training in cCBT	Training in cCBT	At the moment, is the healthcare professional trained for providing cCBT?	1=Yes; 2=No	Questionnaire	Healthcare professional	Pre-treatment

A.2 Domain 2: Patient safety (cCBT)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Suicidality	12	Ideation	Severe active thoughts of committing suicide	Has the patient being thinking lately to end his/her life?	1=Yes; 2=No	ROM, patient file, if self-help: patient questionnaire.	Patient	Notified by healthcare professional
	13	Attempts	Acts of taking one's own life intentionally.	During treatment, has the patient attempted to commit suicide?	1=Yes; 2=No	ROM, patient file, if self-help: patient questionnaire.	Patient	Notified by healthcare professional
Dropout	See indicators 23-27							
Perceived safety	14	Safety	Whether the healthcare professional perceives the intervention as safe for the patient.	Since part of the treatment is delivered online, do you feel the treatment is safe for the patient? Why / why not? What might be the risks to patients and how can this be overcome?		Focus-group interview	Healthcare professional	Post study

A.3 Domain 3: Clinical effectiveness (cCBT)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Diagnosis	15	Symptoms	Symptom severity	How severe are the patient's depressive symptoms?	1=No symptoms are experienced; 2=symptoms are mild; 3=symptoms are moderate; 4=symptoms are severe; 5=symptoms are very severe	Data extraction query or questionnaire	Patient	ROM, Pre & post treatment
	16	Episodes	Duration of current depressive episode	For what period is the patient experiencing a depression?	1=less than 4 weeks; 2=between 4 and 8 weeks; 3= between 8 and 12 weeks; 4=between 3 and 6 months; 5=6 months to a year; 6=between 1 year and 3 years; 7= 3 to 5 years; 8=5 to 10 years; 9= more than 10 years	Data extraction query or questionnaire	Patient	Pre treatment
	17a	Methodology	Method	How is the severity of the symptoms established?	1=Through a clinical interview; 2=through a clinical professional judgement; 3=through a questionnaire; 4=other	Data extraction query or questionnaire	Patient	Pre treatment

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	17b			If a clinical interview or questionnaire is used, please name	1=PHQ-9; 2=BDI; 3=QIDS; 4=HADS; 5=CDS; 6=CAD; 7=CES-D; 8=DASS; 9=Other	Data extraction query or questionnaire	Patient	Pre treatment
	17c			If a clinical interview or questionnaire is used, what is the sub score for depression? (or if a sub score for depression is not available, what is the total score?)	Score number	Data extraction query or questionnaire	Patient	Pre treatment
	18	Referral	cCBT referral	Who referred the patient to the cCBT treatment program?	1=General practitioner; 2=Psychiatrist; 3=Psychologist; 4=Other mental health professional; 5=Self-referral; 6=Other	Data extraction query or questionnaire	Patient	Pre treatment
Pharmaco-therapy	19	ADM	Whether the patient receives antidepressant agents	At the moment, does the patient use antidepressant medication?	1=yes, for less than one month; 2=yes for less than 2 months; 3=yes for more than 2 months; 4=no	Data extraction query or questionnaire	Patient	Pre treatment
Quality of Life	20	Satisfaction with life	Life	How satisfied are you with your life as a whole today?	1=Couldn't be worse; 2…6; 7=couldn't be better	MANSA	Patient	ROM, pre & post treatment
			Mental health	How satisfied are you with your mental health?	1=Couldn't be worse; 2…6; 7=couldn't be better	MANSA	Patient	ROM, pre & post treatment
Access	21	System logon	Number of logons to the systems	How many times did the patient logon to the treatment platform?	Round number; not available	Data extraction query	Patient	Post treatment
	22	cCBT access	Location of main access to the online treatment	At what location has the patient accessed the online treatment sessions?	1=Individual; 2=Community location; 3=at care institution	Questionnaire	Patient	Post treatment
Drop-out	23	Sessions planned	Total number of therapeutic sessions that are included in the intended treatment?	In total, how much sessions are included in the intended treatment?	Round number	Data extraction query or questionnaire	Patient	Post treatment
	24	Sessions completed	Total number therapeutic sessions	In total, how much sessions are completed? This includes both sessions provided face-to-face and online.	Round number	Data extraction query or questionnaire	Patient	Post treatment
	25	Completed online	Completed online therapeutic sessions	How many online sessions are completed?	Round number	Data extraction query or questionnaire	Patient	Post treatment

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	26	Patient's reasons for not completing treatment as intended	Reasons for dropout for those patients who started the treatment but not ended it as initially planned.	What were the reasons to end the therapy and not finish all sessions as intended?	A. For technical reasons: 1=I had problems with my internet connection and/or my computer was not functioning; 2=I don't have a computer; 3=I don't trust the online sessions are secure; 4=I don't have enough skills to follow the online sessions; 5=other; B. For personal reasons: 1=I forgot to attend the online sessions; 2=I ran out of time; 3=I was ill; 4=I had to work; 5=My family did not support me; 6=I did not want to share my personal information through the internet; 7=Other; C. for therapeutic reasons: 1=I am not convinced that the therapy solves my problems; 2=the healthcare professional and the I came to the conclusion it had no use for the patient to continue treatment; 3=my mental problems are alleviated; 4=other	Questionnaire	Patient	Post treatment
	27	Healthcare professional perspective on reasons for drop-out	[in general] Reasons for dropout for those patients who started the treatment but not ended it as initially planned.	In general, what were the reasons to not complete the therapy as intended?		Focus-group interview	Healthcare professional	Post study

A.4 Domain 4: Patient and Healthcare professional perspectives (cCBT)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Patient perceived satisfaction	28	Quality	Perceived quality of the service(s) received	How would you rate the quality of the treatment you have received?	4=Excellent; 3=Good; 2=Fair; 1=Poor; if fair, poor: why?	CSQ-8	Patient	Post-treatment
	29	Preferences	The extent the service adheres to patients' preferences	Did you get the kind of treatment you wanted?	1=No, definitely; 2=No, not really; 3=Yes, generally; 4=Yes, definitely	CSQ-8	Patient	Post-treatment
	30	Needs	The extent the service adheres to patients' needs	To what extent has the treatment met your needs?	4=Almost all of my needs have been met; 3=Most of my needs have been met; 2=Only a few of my needs have been met; 1=None of my needs have been met	CSQ-8	Patient	Post-treatment
	31	Recommending	Whether or not the patient would recommend the service to friends	If a friend were in need of similar help, would you recommend this treatment to him or her?	1=No, definitely not; 2=No, I don't think so; 3=Yes, I think so; 4=Yes, definitely	CSQ-8	Patient	Post-treatment
	32	Help	The extent the patient is satisfied with the help received	How satisfied are you with the amount of help you have received?	1=Quite dissatisfied; 2=Indifferent or mildly dissatisfied; 3 Mostly satisfied; 4=Very satisfied	CSQ-8	Patient	Post-treatment

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	33	Efficacy	The extent the patient is satisfied with the service received	Has the treatment you received helped you to deal more effectively with your problems?	4=Yes, they helped a great deal; 3=Yes, they helped; 2=No, they really didn't help; 1=No, they seemed to make things worse	CSQ-8	Patient	Post-treatment
	34	Satisfaction	The extent the patient is satisfied with the service received.	In an overall, general senses, how satisfied are you with the treatment you have received?	4=Very satisfied; 3=mostly satisfied; 2=indifferent or mildly satisfied; 1=quite dissatisfied	CSQ-8	Patient	Post-treatment
	35	Return	Whether or not the patient would return if help is needed again	If you were to seek help again, would you make use of this treatment again?	1=No, definitely not; 2=No, I don't think so; 3=Yes, I think so; 4=Yes, definitely	CSQ-8	Patient	Post-treatment
Patient perceived usability	36	Frequency	The extent the patient would like the online part of the therapy more often.	I think that I would like to use and apply the treatment frequently when needed.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	37	Complexity	The extent the patient found the online part of the therapy complex	I found the treatment unnecessarily complex.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	38	Easiness	The extent the patient found the online part of the therapy easy to use	I thought the treatment was easy to use and apply.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	39	Ability	The extent the patient needed technical support to be able to use the online part of the therapy	I think that I would need the support of a technical person to be able to use and apply the treatment more often.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	40	Integration	The extent the patient found the different functions of the online part of the therapy are well integrated	I found the various functions in the treatment were well integrated.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	41	Consistency	The extent the patient found the online part of the therapy consistent	I thought there was too much inconsistency in the treatment.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	42	Learning speed	The extent the patient imagines people's learning speed with the online therapy	I can imagine that most people would learn to use and apply the treatment very quickly.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	43	Difficulty	The extent the patient found the online therapy difficult to use	I found the treatment very cumbersome to use and apply.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	44	Confidence	The extent the patient felt confidence with using the online therapy	I felt very confident using and applying the treatment.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	45	Amount of learning	The extent the patient needed to learn to use the only therapy	I needed to learn a lot of things before I could get going with the treatment.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Healthcare professional perceived satisfaction with cCBT	46	Needs	The extent cCBT adheres to healthcare professionals' needs	To what extent has this cCBT intervention met your needs in treating patients?	4=Almost all of my needs have been met; 3=Most of my needs have been met; 2=Only a few of my needs have been met; 1=None of my needs have been met	CSQ-3	Healthcare professional	Study end
	47	Satisfaction	The extent the healthcare professional is satisfied with the cCBT provided to their clients.	In an overall general sense, how satisfied are you with the cCBT intervention in treating your patients?	4=Very satisfied; 3=mostly satisfied; 2=indifferent or mildly satisfied; 1=quite dissatisfied	CSQ-3	Healthcare professional	Study end
	48	Return	Whether or not the healthcare professional would use cCBT again.	If you were to provide a CBT treatment again, would you use cCBT again?	1=No, definitely not; 2=No, I don't think so; 3=Yes, I think so; 4=Yes, definitely	CSQ-3	Healthcare professional	Study end
Healthcare professional perceived usability with cCBT	49	Frequency	The extent the healthcare professional would like to offer cCBT more often.	I think that I would like to provide the cCBT treatment more frequently.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	50	Complexity	The extent the healthcare professional found cCBT complex	I found the cCBT treatment or process unnecessarily complex.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	51	Easiness	The extent the healthcare professional found cCBT easy to use and provide	I find the cCBT treatment or process was easy to use.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	52	Ability	The extent the healthcare professional needed technical support to be able to use and provide cCBT.	I think that I would need the support of a technical person to be able to use and provide the cCBT treatment for my clients.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	53	Integration	The extent the healthcare professional found the different functions of cCBT are well integrated	I found the various functions in the cCBT intervention or process were well integrated.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	54	Consistency	The extent the healthcare professional found cCBT consistent	I thought there was too much inconsistency in the cCBT intervention or process.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	55	Learning speed	The extent the healthcare professional imagines healthcare professionals' learning speed with the cCBT is quick	I can imagine that most healthcare professionals would learn to use and provide the cCBT intervention or process very quickly.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	56	Difficulty	The extent the healthcare professional found cCBT difficult to use and provide	I found the cCBT intervention or process very cumbersome to use and provide to my clients.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	57	Confidence	The extent the healthcare professional felt confidence with using and providing cCBT	I felt very confident using and providing the cCBT intervention or process to my clients.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	58	Amount of learning	The extent the healthcare professional needed to learn new things to use and provide cCBT	I needed to learn a lot of things before I could get going with using and providing the cCBT intervention to my clients.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end

A.5 Domain 5: Economic aspects (cCBT)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Investment	59	Support staff	Incidental efforts (time) needed of *support staff* to implement cCBT	If you need to estimate, how much additional time of support services is needed to support healthcare professionals to implement cCBT in their daily routine?	FTE	Questionnaire	Organisation	Post study
	60	Materials	Investment costs for additional materials such as ICT infrastructure	In total, how much is invested in ICT infrastructure to be able to implement cCBT in the daily practice of the organisation?	Costs in Euro	Questionnaire	Organisation	Post study
	61	Training	Initial Training and supervision	Did the users of the system receive a dedicated training? If so, what training did they receive and if not, why not?	1=yes, 2=no, 3=why	Questionnaire	Organisation	Post study
Recurrent operational costs	62	Direct costs	Direct costs of cCBT for one session	What are the direct costs such as licenses, service level agreements, and maintenance and ICT infrastructure?	Costs in Euro	Questionnaire	Organisation	Post study
	63	Indirect costs	What are the costs spend on overheads of cCBT for one session?	What are the costs spend on overheads such as office rent, gas, heating/cooling, administration, etc.? Or: what percentage of the total costs normally is spend on overheads?	Costs in Euro	Questionnaire	Organisation	Post study
Sustainability	64	Business case	A business case captures the reasoning for initiating or retaining a project and investment.	Based on the findings in the study, is a business case for deciding whether or not to retain and maintain the intervention in the organisation? Why? What are the long-term effects?		Structured interview	Organisation	Post study
	65	Funding strategies	Funding is essential in maintaining an intervention.	Is there adequate funding for maintenance of the intervention? What funding strategies are in place? How is reimbursement arranged for?		Structured interview	Organisation	Post study
	66	Rationales	The most important reasons for sustaining cCBT in the organisation	What are the most important reasons for keeping the service implemented in the organisation?		Structured interview	Organisation	Post study

A.6 Domain 6: Organisational aspects (cCBT)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Organisation size	67	Units	Number of units or departments that can be distinguished in either function or responsibility within the organisation	Approximately, how many units or departments can be distinguished in your organisation?	Round number	Questionnaire	Organisation	Post study
	68	FTE	Number of total Full time equivalent (FTE) jobs the organisation constitutes	Approximately, how many FTE are currently employed at your organisation?	FTE	Questionnaire	Organisation	Post study
Age	69	Age	Year the organisation is officially established	In what year is your organisation officially been established?	Year	Questionnaire	Organisation	Post study
Healthcare professional caseload	70	Caseload	The amount of cases that a healthcare professional handles each year.	On average, how many clients do you weekly see?	Number	Questionnaire	Healthcare professional	Post study (retrospectivel y to pre)
	71	Working arrangement	Whether the healthcare professional works full-time or not.	Is your employment full-time or part-time?	1=Full time; 2=Part time for 0.## FTE	Questionnaire	Healthcare professional	Post study (retrospectivel y to pre
	72	Case management	The estimate of work spent on related activities (not providing active treatment) such as administration, case management and other care related work	What proportion of your work is devoted to care related activities but not providing the actual treatments? Examples are case management, administrative tasks, etc.	Percentage	Questionnaire	Healthcare professional	Post study (retrospectivel y to pre
Leadership engagement	73	Commitment – org. view	Commitment, involvement, and accountability of leaders and managers	To what extent is the management engaged in implementing cCBT? How?		Structured interview	Organisation	Post study
	74	Commitment – healthcare professional view	Commitment, involvement, and accountability of leaders and managers	To what extent are your mangers or leaders engaged in implementing cCBT? How?		Focus-group interview	Healthcare professional	Post study
	75	Implementation strategy – org view	Use of a dedicate implementation strategy to plan, engage, execute and evaluate implementation of the interventions	To what extent is made use of a dedicated Implementation Strategy? (Strategy that contains activities that are structured according to the following phases: planning, engaging, executing and evaluation); to what extend is it used and operationalized? Why?		Structured interview	Organisation	Post study
	76	Implementation strategy – healthcare professional view	Use of a dedicate implementation strategy to plan, engage, execute and evaluate implementation of the interventions	To what extent is made use of a dedicated Implementation Strategy? (Strategy that contains activities that are structured according to the following phases: planning, engaging, executing and evaluation); to what extend is it used and operationalized? Why?		Focus-group interview	Healthcare professional	Post study
Resources	77	Time – org. view	Whether or not healthcare professionals officially receive extra time for implementing the intervention in their daily practice	Are the healthcare professionals in your organisation allowed to spend extra time in treating clients with the intervention so you are able to implement it in your daily routine? Is it enough?		Structured interview	Organisation	Post study

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	78	Time – healthcare professional view	Whether or not healthcare professionals officially receive extra time for implementing the intervention in their daily practice	As a healthcare professional, are you allowed to spend extra time in treating clients with the intervention so you are able to implement it in your daily routine? Is it enough?		Focus-group interview	Healthcare professional	Post study
	79	Therapist time	Therapist time per patient	Was therapists' time per patient treated affected after the implementation of cCBT/ccVC in their daily routine? If so, could you estimate by how much? (E.g. increase/decrease by X in the number of patients treated per day by a therapist)		Focus-group interview	Healthcare professional	Post study
	80	Resource savings	Resource savings	Have you observed any resource savings due to the implementation of cCBT/ccVC other than therapist's time? If so, could you estimate where and by how much?		Focus-group interview	Healthcare professional	Post study
Perspective on implementation	81	Factors for success – org view	Whether the implemented intervention will actually be sustained in the organisation	From the organisation's viewpoint, what are the most important factors that determine whether or not an implemented intervention is sustained in the organisation and why? How is this measured?		Structured interview	Organisation	Post study
	82	Factors for success – healthcare professional view	Whether the implemented intervention will actually be sustained in the organisation	From your viewpoint, what are the most important factors that determine whether or not an implemented intervention is successful? How is this measured?		Focus-group interview	Healthcare professional	Post study
Knowledge and beliefs about the intervention	83	Attitude	Healthcare professional's attitudes toward the intervention	To what extent are you enthusiastic about using cCBT in treating your clients? What part the most and what the least?		Focus-group interview	Healthcare professional	Post study
Self-efficacy	84	Confidence	Individual belief in their own capabilities to execute courses of action to achieve implementation goals	To what extent do you feel confident in your own ability to use cCBT in treating your clients? What part the most, and what the least?		Focus-group interview	Healthcare professional	Post study
Individual stage of change	85	State of change	Characterization of the phase an healthcare professional is in, as he or she progresses toward skilled, enthusiastic, and sustained use of the intervention	On the continuum of change, in what state are you currently?		Focus-group interview	Healthcare professional	Post study
Healthcare professional identification with organisation	86	Commitment	A broad construct related to how healthcare professionals perceive the degree of commitment with that organization.	To what extent are you committed to the goals of your organisation?		Focus-group interview	Healthcare professional	Post study
	87	Loyalty	A broad construct related to how healthcare professionals perceive the organization and their relationship and with that organization.	To what extent are you loyal to your organisation?		Focus-group interview	Healthcare professional	Post study
Support	88	Support for treating patients	The extent in which healthcare professionals are supported and encouraged in applying the therapy	To what extent do you feel supported and encouraged by your organisation in applying new and novel ways of working in your daily practice?		Focus-group interview	Healthcare professional	Post study

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Rewards	89	Recognition	The extent in which the healthcare professionals are recognised within their organisation for starting to use the intervention	To what extent do you feel recognised by your organisation when incorporating a new intervention in your daily practice? How does this take place?		Focus-group interview	Healthcare professional	Post study
	90	Appreciation	The extent in which healthcare professionals are officially appreciated within their organisation in using the intervention	How and to what extent do you feel appreciated in doing that?		Focus-group interview	Healthcare professional	Post study
Relative priority	91	Relative priority	Healthcare professional's shared perception of the importance of the implementation within the organization	What priority do you give to implementing cCBT in your practice? Why?		Focus-group interview	Healthcare professional	Post study

A.7 Domain 7: Socio, ethical and legal aspects (cCBT)

Dimension	Indicator		Definition	Questions	Instrument	Level	Time point
Public policy and regulation	92	Clinical guidelines in practice	A document that guides decisions and criteria regarding diagnosis, management, and treatment in mental health care	How important are clinical guidelines in your organisation and how are they embedded/implemented in your organisation? Why or why not?	Focus-group interview	Org. and Healthcare professional	Post study
	93	Public image through benchmarking	A measurement of the quality of an organization's policies, products, programs, strategies, etc., and their comparison with standard measurements, or similar measurements of its peers.	Will the implementation of cCBT do well to your public image and in e.g. benchmarking in the healthcare market? Why?	Focus-group interview	Org. and Healthcare professional	Post study
Conflict	94	Professional liability	The extent in which the healthcare professional feels comfortable in using the intervention regarding his/her professional liability towards the patient.	Does intervention provides enough tools for me to bear my professional liability in counselling and treating the patient? How does this work?	Focus-group interview	Org. and Healthcare professional	Post study

Appendix B: Indicators and measurements for ccVC

B.1 Domain 1: Health problem and general characteristics: patient and healthcare professional profiles (ccVC)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Patient demographics	95	Age	The length of time a person lived	What is the patient's age?	Number of years from birth	Data extraction query or questionnaire	Patient	Pre-treatment
	96	Gender	Main category based on reproductive function	What is the patient's gender?	1=Male; 2=Female	Data extraction query or questionnaire	Patient	Pre-treatment
	97	Education	Highest level of completed education	What is the highest level of education the patient received and completed?	1=Primary; 2=Secondary; 3=Higher and/or University; 4=Other	Data extraction query or questionnaire	Patient	Pre-treatment
	98	Immigration	Ancestry of the patient	Has the patient or one of his/hers parents immigrated to the country he/she now resides?	1=Yes; 2=No	Data extraction query or questionnaire	Patient	Pre-treatment
	99	Residency	Current main place of living.	What is the postal code the patient currently resides in?	Postal code	Data extraction query or questionnaire	Patient	Pre-treatment
	100	Employment	Employment	What is your current employment status?	1=Working full time; 2=Working part time; 3=On sick leave; 4=Unemployed; 5=Disability pension; 6=Pensioner; 7=other	Data extraction query or questionnaire	Patient	Pre-treatment
Healthcare professional demographics	101	Gender	Main category based on reproductive function	What is the gender of the healthcare professional providing the treatment?	1=Male; 2=Female	Questionnaire	Healthcare professional	Pre-treatment
Professional experience	102	Profession	The healthcare professional's profession	What is the official profession of the healthcare professional providing the treatment?	1=GP; 2=Licensed psychologist; 3=Psychologist in training under supervision; 4=Psychologist with completed basic training; 5=Psychiatrist; 6=Psychiatrist with informal training in CBT; 7=Psychiatrist with a diploma in CBT; 8=Psychiatrist with a master; 9=Psychiatrist with a doctorate; 10=Mental health worker or community location staff; 11=Central administrator; 12=Other	Questionnaire	Healthcare professional	Pre-treatment
	103	Field experience	The number of years the healthcare professional has experience in mental health care	In years, how much experience has the healthcare professional in mental health care?	1=less than 3 years; 2=3 years or more but less than 5 years; 3=5 years or more, but less than 10 years; 4=10 years or more	Questionnaire	Healthcare professional	Pre-treatment

	104	ccVC experience	Experience in using ccVC	How many times did the healthcare professional use ccVC services before?	1=0-4 times, 2=5-9 times, 3=10-14 times, 4=15-19 times; 5=more than 20 times	Questionnaire	Healthcare professional	Pre-treatment

B.2 Domain 2: Patient safety (ccVC)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Suicidality	105	Ideation	Severe active thoughts of committing suicide	Has the patient being thinking lately to end his/her life?	1=Yes; 2=No	ROM, patient file, if self-help: patient questionnaire.	Patient	Notified by healthcare professional
	106	Attempts	Acts of taking one's own life intentionally.	During treatment, has the patient attempted to commit suicide?	1=Yes; 2=No	ROM, patient file, if self-help: patient questionnaire.	Patient	Notified by healthcare professional
Dropout	See indicators 116-119							
Perceived safety	107	Safety	Whether the healthcare professional perceives the intervention as safe for the patient.	Since part of the treatment is delivered online, do you feel the treatment is safe for the patient? Why / why not? What might be the risks to patients and how can this be overcome?		Focus-group interview	Healthcare professional	Post study

B.3 Domain 3: Clinical effectiveness (ccVC)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Diagnosis	108	Symptoms	Symptom severity	How severe are the patient's depressive symptoms?	1=No symptoms are experienced; 2=symptoms are mild; 3=symptoms are moderate; 4=symptoms are severe; 5=symptoms are very severe	Data extraction query or questionnaire	Patient	ROM, Pre & post treatment
	109	Episodes	Duration of current depressive episode	For what period is the patient experiencing a depression?	1=less than 4 weeks; 2=between 4 and 8 weeks; 3=between 8 and 12 weeks; 4= more than 12 weeks; and then some longer options (presumably not very frequent);	Data extraction query or questionnaire	Patient	Pre treatment
	110a	Methodology	Method	How is the severity of the symptoms established?	1=Through a clinical interview; 2=through a clinical professional judgement; 3=through a questionnaire; 4=other	Data extraction query or questionnaire	Patient	Pre treatment
	110b			If a clinical interview or questionnaire is used, please name	1=PHQ-9; 2=BDI; 3=QIDS; 4=HADS; 5=CDS; 6=CAD; 7=CES-D; 8=DASS; 9=Other	Data extraction query or questionnaire	Patient	Pre treatment

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	110c			If a clinical interview or questionnaire is used, what is the sub score for depression? (or if a sub score for depression is not available, what is the total score?)	number	Data extraction query or questionnaire	Patient	Pre treatment
	111	Referral	ccVC referral	Who referred the patient to the ccVC treatment program?	1=General practitioner; 2=Psychiatrist; 3=Psychologist; 4=Other mental health professional; 5=Self-referral; 6=Other	Data extraction query or questionnaire	Patient	Pre treatment
Pharmaco-therapy	112	ADM	Whether the patient receives antidepressant agents	At the moment, does the patient use antidepressant medication?	1=yes, for less than one month; 2=yes for less than 2 months; 3=yes for more than 2 months; 4=no	Data extraction query or questionnaire	Patient	Pre treatment
Quality of Life	113	Satisfaction with life	Life	How satisfied are you with your life as a whole today?	1=Couldn't be worse; 2…6; 7=couldn't be better	MANSA	Patient	ROM, pre & post treatment
			Mental health	How satisfied are you with your mental health?	1=Couldn't be worse; 2…6; 7=couldn't be better	MANSA	Patient	ROM, pre & post treatment
Access	114	Times used ccVC	Number of logons to the systems	How many times did the patient use the ccVC system?	Round number	Data extraction query	Patient	Post treatment
	115	ccVC access	Location of main access to ccVC	At what location has the patient accessed ccVC sessions?	1=Individual; 2=Community location; 3=at care institution	Questionnaire	Patient	Post treatment
Dropout	116	Completed ccVC sessions	Completed ccVC sessions	How many ccVC sessions are completed?	Round number	Data extraction query or questionnaire	Patient	Post treatment
	117	Patient's reasons for not completing treatment as intended	Reasons for dropout for those patients who started the treatment but not ended it as initially planned.	What were the reasons to end the therapy and not finish all sessions as intended?	A. For technical reasons: 1=I had problems with my internet connection and/or my computer was not functioning; 2=I don't have a computer; 3=I don't trust the online sessions are secure; 4=I don't have enough skills to follow the online sessions; 5=other; B. For personal reasons: 1=I forgot to attend the online sessions; 2=I ran out of time; 3=I was ill; 4=I had to work; 5=My family did not support me; 6=I did not want to share my personal information through the internet; 7=Other; C. for therapeutic reasons: 1=I am not convinced that the therapy solves my problems; 2=the healthcare professional and the I came to the conclusion it had no use for the patient to continue treatment; 3=my mental problems are alleviated; 4=other	Questionnaire	Patient	Post treatment

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	118	Healthcare professional perspective on reasons for drop-out	[in general] Reasons for dropout for those patients who started the treatment but not ended it as initially planned.	In general, what were the reasons to not complete the therapy as intended?		Focus-group interview	Healthcare professional	Post study

B.4 Domain 4: Patient and Healthcare professional perspectives (ccVC)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Patient perceived satisfaction with ccVC	119	Quality	Perceived quality of the service(s) received	How would you rate the quality of the service you have received?	4=Excellent; 3=Good; 2=Fair; 1=Poor; if fair, poor: why?	CSQ-8	Patient	Post-treatment
	120	Preferences	The extent the service adheres to patients' preferences	Did you get the kind of service you wanted?	1=No, definitely; 2=No, not really; 3=Yes, generally; 4=Yes, definitely	CSQ-8	Patient	Post-treatment
	121	Needs	The extent the service adheres to patients' needs	To what extent has the service met your needs?	4=Almost all of my needs have been met; 3=Most of my needs have been met; 2=Only a few of my needs have been met; 1=None of my needs have been met	CSQ-8	Patient	Post-treatment
	122	Recommending	Whether or not the patient would recommend the service to friends	If a friend were in need of similar help, would you recommend this service to him or her?	1=No, definitely not; 2=No, I don't think so; 3=Yes, I think so; 4=Yes, definitely	CSQ-8	Patient	Post-treatment
	123	Help	The extent the patient is satisfied with the help received	How satisfied are you with the amount of help you have received?	1=Quite dissatisfied; 2=Indifferent or mildly dissatisfied; 3 Mostly satisfied; 4=Very satisfied	CSQ-8	Patient	Post-treatment
	124	Efficacy	The extent the patient is satisfied with the service received	Has the service you received helped you to deal more effectively with your problems?	4=Yes, they helped a great deal; 3=Yes, they helped; 2=No, they really didn't help; 1=No, they seemed to make things worse	CSQ-8	Patient	Post-treatment
	125	Satisfaction	The extent the patient is satisfied with the service received.	In an overall, general senses, how satisfied are you with the service you have received?	4=Very satisfied; 3=mostly satisfied; 2=indifferent or mildly satisfied; 1=quite dissatisfied	CSQ-8	Patient	Post-treatment
	126	Return	Whether or not the patient would return if help is needed again	If you were to seek help again, would you make use of this service again?	1=No, definitely not; 2=No, I don't think so; 3=Yes, I think so; 4=Yes, definitely	CSQ-8	Patient	Post-treatment
Patient perceived usability with ccVC	127	Frequency	The extent the patient would like the online part of the therapy more often.	I think that I would like to use and apply the service frequently when needed.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	128	Complexity	The extent the patient found the online part of the therapy complex	I found the service unnecessarily complex.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	129	Easiness	The extent the patient found the online part of the therapy easy to use	I thought the service was easy to use and apply.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	130	Ability	The extent the patient needed technical support to be able to use the online part of the therapy	I think that I would need the support of a technical person to be able to use and apply the service more often.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	131	Integration	The extent the patient found the different functions of the online part of the therapy are well integrated	I found the various functions in the service were well integrated.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	132	Consistency	The extent the patient found the online part of the therapy consistent	I thought there was too much inconsistency in the service.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	133	Learning speed	The extent the patient imagines people's learning speed with the online therapy	I can imagine that most people would learn to use and apply the service very quickly.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	134	Difficulty	The extent the patient found the online therapy difficult to use	I found the service very cumbersome to use and apply.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	135	Confidence	The extent the patient felt confidence with using the online therapy	I felt very confident using and applying the service.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
	136	Amount of learning	The extent the patient needed to learn to use the only therapy	I needed to learn a lot of things before I could get going with the service.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Patient	Post-treatment
Healthcare professional perceived satisfaction with ccVC	137	Needs	The extent the ccVC services adhere to healthcare professionals' needs	To what extent has these ccVC services met your needs in treating patients?	4=Almost all of my needs have been met; 3=Most of my needs have been met; 2=Only a few of my needs have been met; 1=None of my needs have been met	CSQ-3	Healthcare professional	Study end
	138	Satisfaction	The extent the healthcare professional is satisfied with using ccVC in treating their clients.	In an overall general sense, how satisfied are you with the ccVC services in delivering treatment?	4=Very satisfied; 3=mostly satisfied; 2=indifferent or mildly satisfied; 1=quite dissatisfied	CSQ-3	Healthcare professional	Study end
	139	Return	Whether or not the healthcare professional would use ccVC services again.	If you were to provide treatment again, would you use the ccVC services again?	1=No, definitely not; 2=No, I don't think so; 3=Yes, I think so; 4=Yes, definitely	CSQ-3	Healthcare professional	Study end
Healthcare professional perceived usability with	140	Frequency	The extent the healthcare professional would like to offer ccVC facilitated treatment more often.	I think that I would like to provide psychological treatment by using ccVC more frequently.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
ccVC	141	Complexity	The extent the healthcare professional found the ccVC services complex	I found the ccVC services unnecessarily complex.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	142	Easiness	The extent the healthcare professional found ccVC services easy to use.	I find the ccVC services easy to use.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	143	Ability	The extent the healthcare professional needed technical support to be able to use the ccVC services.	I think that I would need the support of a technical person to be able to use ccVC services in treating my clients.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	144	Integration	The extent the healthcare professional found the different functions of ccVC are well integrated	I found the various functions in the ccVC services were well integrated.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	145	Consistency	The extent the healthcare professional found the ccVC services consistent	I thought there was too much inconsistency in the ccVC services.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	146	Learning speed	The extent the healthcare professional imagines healthcare professionals' learning speed in using ccVC services is quick	I can imagine that most healthcare professionals would learn to use ccVC services very quickly.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	147	Difficulty	The extent the healthcare professional found the ccVC services difficult to use.	I found the ccVC services very cumbersome to use in treating my clients.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	148	Confidence	The extent the healthcare professional felt confidence with using the ccVC services	I felt very confident using ccVC services in treating my clients.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end
	149	Amount of learning	The extent the healthcare professional needed to learn new things to use the ccVC services	I needed to learn a lot of things before I could get going with using the ccVC services in treating my clients.	1=I strongly disagree; 2=I disagree; 3=I don't disagree nor agree; 4=I agree; 5=I strongly agree	SUS	Healthcare professional	Study end

B.5 Domain 5: Economic aspects (ccVC)

Dimension	Indicator		Definition	Questions		Instrument	Level	Time point
Investment	150	Support staff	Incidental efforts (time) needed of *support staff* to implement ccVC	If you need to estimate, how much additional supportive time is needed to support healthcare professionals to implement ccVC services in their daily routine?	FTE	Questionnaire	Organisation	Post study

Dimension	Indicator		Definition	Questions		Instrument	Level	Time point
	151	Materials	Investment costs for additional materials such as ICT infrastructure	In total, how much is invested in ICT infrastructure to be able to implement ccVC in the daily practice of the organisation?	Costs in Euro	Questionnaire	Organisation	Post study
	152	Training	Initial Training and supervision	Did the users of the system receive a dedicated training? If so, what training did they receive and if not, why not?	Yes, no, why	Questionnaire	Organisation	Post study
Recurrent operational costs	153	Direct costs	Direct costs of ccVC for one session	What are the direct costs such as licenses, service level agreements, and maintenance and ICT infrastructure?	Costs in Euro	Questionnaire	Organisation	Post study
	154	Indirect costs	What are the costs spend on overheads of ccVC for one session?	What are the costs spend on overheads such as office rent, gas, heating/cooling, administration, etc.? Or: what percentage of the total costs normally is spend on overheads?	Costs in Euro	Questionnaire	Organisation	Post study
Sustainability	155	Business case	A business case captures the reasoning for initiating or retaining a project and investment.	Based on the finding of the study, is a business case for deciding whether or not to retain and maintain the intervention in the organisation? Why? What are the long-term effects?		Focus-group interview	Organisation	Post study
	156	Funding strategies	Funding is essential in maintaining an intervention.	Is there adequate funding for maintenance of the intervention? What funding strategies are in place? How is reimbursement arranged for?		Focus-group interview	Organisation	Post study
	157	Rationales	The most important reasons for sustaining ccVC in the organisation	What are the most important reasons for keeping the service implemented in the organisation?		Focus-group interview	Organisation	Post study

B.6 Domain 6: Organisational aspects (ccVC)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Organisation size	158	Units	Number of units or departments that can be distinguished in either function or responsibility within the organisation	Approximately, how many units or departments can be distinguished in your organisation?		Focus-group interview	Organisation	Post study
	159	FTE	Number of total Full time equivalent (FTE) jobs the organisation constitutes	Approximately, how many FTE are currently employed at your organisation?		Focus-group interview	Organisation	Post study
Age	160	Age	Year the organisation is officially established	In what year is your organisation officially been established?		Focus-group interview	Organisation	Post study
Healthcare professional caseload	161	Caseload	The amount of cases that a healthcare professional sees each year.	On average, how many clients do you weekly see?	Number	Questionnaire	Healthcare professional	Post study (retrospectively to pre)

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
	162	Working arrangement	Whether the healthcare professional works full-time or not.	Is your employment full-time or part-time?	1=Full time; 2=Part time for 0.## FTE	Questionnaire	Healthcare professional	Post study (retrospectively to pre
	163	Case management	The estimate of work spent on related activities (not providing active treatment) such as administrative, case management and other care related work.	What proportion of your work is devoted to care related activities but not providing the actual treatments? Examples are case management, administrative tasks, etc.	Percentage	Questionnaire	Healthcare professional	Post study (retrospectively to pre
Leadership engagement	164	Commitment – org. view	Commitment, involvement, and accountability of leaders and managers	To what extent is the management engaged in implementing cCBT or ccVC? How?		Structured interview	Organisation	Post study
	165	Commitment – healthcare professional view	Commitment, involvement, and accountability of leaders and managers.	To what extent are your mangers or leaders engaged in implementing ccVC? How?		Focus-group interview	Healthcare professional	Post study
	166	Implementation strategy – org view	Use of a dedicate implementation strategy to plan, engage, execute and evaluate implementation of the interventions	To what extent is made use of a dedicated Implementation Strategy? (Strategy that contains activities that are structured according to the following phases: planning, engaging, executing and evaluation); to what extend is it used and operationalized? Why?		Structured interview	Organisation	Post study
	167	Implementation strategy – healthcare professional view	Use of a dedicate implementation strategy to plan, engage, execute and evaluate implementation of the interventions	To what extent is made use of a dedicated Implementation Strategy? (Strategy that contains activities that are structured according to the following phases: planning, engaging, executing and evaluation); to what extend is it used and operationalized? Why?		Focus-group interview	Healthcare professional	Post study
Resources	168	Time – org. view	Whether or not healthcare professionals officially receive extra time for implementing the intervention in their daily practice	Are the healthcare professionals in your organisation allowed to spend extra time in treating clients with the intervention so you are able to implement it in your daily routine? Is it enough?		Structured interview	Organisation	Post study
	169	Time – healthcare professional view	Whether or not healthcare professionals officially receive extra time for implementing the intervention in their daily practice	As a healthcare professional, are you allowed to spend extra time in treating clients with the intervention so you are able to implement it in your daily routine? Is it enough?		Focus-group interview	Healthcare professional	Post study
Perspective on implementation	170	Factors for success – org view	Whether the implemented intervention will actually be sustained in the organisation	From the organisation's viewpoint, what are the most important factors that determine whether or not an implemented intervention is sustained in the organisation and why? How is this measured?		Structured interview	Organisation	Post study
	171	Factors for success – healthcare professional view	Whether the implemented intervention will actually be sustained in the organisation	What are the most important factors that determine whether or not an implemented intervention is sustained in the organisation and why? How is this measured?		Focus-group interview	Org. and Healthcare professional	Post study

Dimension	Indicator		Definition	Questions	Unit / Categories	Instrument	Level	Time point
Knowledge and beliefs about the intervention	172	Attitude	Healthcare professional's attitudes toward the intervention	To what extent are you enthusiastic about using ccVC in treating your clients? What part the most and what the least?		Focus-group interview	Healthcare professional	Post study
Self-efficacy	173	Confidence	Individual belief in their own capabilities to execute courses of action to achieve implementation goals	To what extent do you feel confident in your own ability to use ccVC in treating your clients? What part the most, and what the least?		Focus-group interview	Healthcare professional	Post study
Individual stage of change	174	State of change	Characterization of the phase an healthcare professional is in, as he or she progresses toward skilled, enthusiastic, and sustained use of the intervention	On the continuum of change, in what state are you currently?		Focus-group interview	Healthcare professional	Post study
Healthcare professional identification with organisation	175	Commitment	A broad construct related to how healthcare professionals perceive the degree of commitment with that organization.	To what extent are you committed to the goals of your organisation?		Focus-group interview	Healthcare professional	Post study
	176	Loyalty	A broad construct related to how healthcare professionals perceive the organization and their relationship and with that organization.	How would you rate your loyalty to your organisation?		Focus-group interview	Healthcare professional	Post study
Support	177	Support for treating patients	The extent in which healthcare professionals are supported and encouraged in applying the therapy	Within my organisation, healthcare professionals get the support they need to treat patients with the interventions. How?		Focus-group interview	Healthcare professional	Post study
Rewards	178	Recognition	The extent in which the healthcare professionals are officially recognised within their organisation for starting to use the intervention	Within my organisation, healthcare professionals receive recognition for treating patients with the intervention. What kind?		Focus-group interview	Healthcare professional	Post study
	179	Appreciation	The extent in which healthcare professionals are officially appreciated within their organisation in using the intervention	Within my organisation, healthcare professionals receive appreciation for treating patients with the intervention. What kind?		Focus-group interview	Healthcare professional	Post study
Relative priority	180	Relative priority	Healthcare professional's shared perception of the importance of the implementation within the organization	What priority do you give to implementing ccVC in your practice? Why?		Focus-group interview	Healthcare professional	Post study

B.7 Domain 7: Socio, ethical and legal aspects (ccVC)

Dimension	Indicator		Definition	Questions	Instrument	Level	Time point
Public policy and regulation	181	Clinical guidelines in practice	A document that guides decisions and criteria regarding diagnosis, management, and treatment in mental health care	How important are clinical guidelines in your organisation and how are they embedded/implemented in your organisation? Why or why not?	Focus-group interview	Org. and Healthcare professional	Post study
	182	Public image through benchmarking	A measurement of the quality of an organization's policies, products, programs, strategies, etc., and their comparison with standard measurements, or similar measurements of its peers.	Will the implementation of ccVC do well to our public image and in e.g. benchmarking? Why?	Focus-group interview	Org. and Healthcare professional	Post study
Conflict	183	Professional liability	The extent in which the healthcare professional feels comfortable in using the intervention regarding his/her professional liability towards the patient.	Does intervention provides enough tools for me to bear my professional liability in counselling and treating the patient? How does this work?	Focus-group interview	Org. and Healthcare professional	Post study

Appendix C: MANSA-2 (both cCBT and ccVC)

1. How satisfied are you with your life as a whole today?

2. How satisfied are you with your mental health?

1	2	3	4	5	6	7
Couldn't be worse	Displeased	Mostly dissatisfied	Mixed	Mostly Satisfied	Pleased	Couldn't be better

Appendix D: CSQ-8

D.1 CSQ-8: Patient - cCBT

Please help us improve our treatment by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much; we really appreciate your help. Circle your answer:

1. How would you rate the quality of the treatment you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of treatment you wanted?

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes, definitely

3. To what extent has the treatment met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend this treatment to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Has the treatment you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped a great deal	Yes, they helped	No, they really didn't help	No, they seemed to make things worse

7. In an overall general sense, how satisfied are you with the treatment you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you make use of this treatment again?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

D.2 CSQ-8: Patient - ccVC

Please help us improve our ccVC service by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much; we really appreciate your help. Circle your answer:

1. How would you rate the quality of the service you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes, definitely

3. To what extent has the service met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend this service to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Has the service you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped a great deal	Yes, they helped	No, they really didn't help	No, they seemed to make things worse

7. In an overall general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you make use of this service again?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Appendix E: CSQ-3

E.1 CSQ-3: Healthcare professional – cCBT

Please help us improve the intervention by answering some questions about the services you used. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much; we really appreciate your help. Circle your answer:

1. To what extent has this cCBT intervention met your needs in treating patients?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

2. In an overall general sense, how satisfied are you with the cCBT intervention in treating your clients?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

3. If you were to provide CBT treatment again, would you use this cCBT intervention again?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

E.2 CSQ-3: Healthcare professional – ccVC

Please help us improve the intervention by answering some questions about the services you used. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much; we really appreciate your help. Circle your answer:

1. To what extent has these ccVC services met your needs in treating patients?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

2. In an overall general sense, how satisfied are you with the ccVC services in treating your clients?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

3. If you were to provide CBT treatment, would you use these ccVC services again?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Appendix F: SUS

F.1 SUS: patient – cCBT

For each of the statements below, please indicate your agreement on a scale from 1 (strongly disagree) to 5 (strongly agree).

1. I think that I would like to use cCBT treatment frequently when needed.
2. I found the cCBT platform unnecessarily complex.
3. I thought the cCBT treatment was easy to use and apply.
4. I think that I would need the support of a technical person to be able to use cCBT treatment more often.
5. I found the various functions in the cCBT treatment were well integrated.
6. I thought there was too much inconsistency in the cCBT treatment.
7. I would imagine that most people would learn to use and apply the cCBT treatment very quickly.
8. I found the cCBT treatment very cumbersome to use and apply.
9. I felt very confident using and applying the cCBT treatment.
10. I needed to learn a lot of things before I could get going with the cCBT treatment.

1	2	3	4	5
I strongly disagree	I disagree	I don't disagree nor agree	I agree	I strongly agree

F.2 SUS: patient – ccVC

For each of the statements below, please indicate your agreement on a scale from 1 (strongly disagree) to 5 (strongly agree).

1. I think that I would like to use ccVC service frequently when needed.
2. I found the ccVC service unnecessarily complex.
3. I thought the ccVC service was easy to use and apply.
4. I think that I would need the support of a technical person to be able to use ccVC service more often.
5. I found the various functions in the ccVC service were well integrated.
6. I thought there was too much inconsistency in the ccVC service.
7. I would imagine that most people would learn to use and apply the ccVC service very quickly.
8. I found the ccVC service very cumbersome to use and apply.
9. I felt very confident using and applying the ccVC service.
10. I needed to learn a lot of things before I could get going with the ccVC service.

1	2	3	4	5
I strongly disagree	I disagree	I don't disagree nor agree	I agree	I strongly agree

F.3 SUS: healthcare professional - cCBT)

For each of the statements below, please indicate your agreement on a scale from 1 (strongly disagree) to 5 (strongly agree).

1. I think that I would like to provide the cCBT treatment frequently.
2. I found the cCBT treatment unnecessarily complex.
3. I thought the cCBT treatment was easy to use and provide to my clients.
4. I think that I would need the support of a technical person to be able to use and provide the cCBT treatment to my clients.
5. I found the various functions in the cCBT intervention were well integrated.
6. I thought there was too much inconsistency in the cCBT intervention.
7. I would imagine that most healthcare professionals would learn to use and provide the cCBT intervention very quickly.
8. I found the cCBT intervention very cumbersome to use and provide to my clients.
9. I felt very confident using and providing the cCBT intervention to my clients.
10. I needed to learn a lot of things before I could get going with using and providing the cCBT intervention to my clients.

1	2	3	4	5
I strongly disagree	I disagree	I don't disagree nor agree	I agree	I strongly agree

F.4 SUS: healthcare professional - ccVC)

For each of the statements below, please indicate your agreement on a scale from 1 (strongly disagree) to 5 (strongly agree).

1. I think that I would like to use the ccVC service frequently.
2. I found the ccVC service unnecessarily complex.
3. I thought the ccVC service was easy to use in treating my clients.
4. I think that I would need the support of a technical person to be able to use the ccVC service in treating my clients.
5. I found the various functions in the ccVC service were well integrated.
6. I thought there was too much inconsistency in the ccVC service.
7. I would imagine that most healthcare professionals would learn to use ccVC service very quickly.
8. I found the ccVC service very cumbersome to use in treating my clients.
9. I felt very confident using the ccVC service in treating my clients.
10. I needed to learn a lot of things before I could get going with using the ccVC service.

1	2	3	4	5
I strongly disagree	I disagree	I don't disagree nor agree	I agree	I strongly agree

Appendix G: Patient Questionnaire

G.1 cCBT

Only applicable if the data is not available in the ROM or in the treatment platform.

Pre-treatment

Indicator	Question	Unit / categories
1	What is your age?	Number of years from birth
2	What is your gender?	1=Male; 2=Female
3	What is the highest level of education you received and completed?	1=Primary; 2=Secondary; 3=Higher and/or University; 4=Other
4	Did you or one of your parents immigrate to the country you now reside?	1=Yes; 2=No
5	What is the postal code you currently reside in?	Postal code
6	Are you currently employed?	1=Yes; 2=No; 3=Not applicable

Post-treatment

Indicator	Question	Unit / categories
23	At what location did you access the online treatment sessions?	1=Individual; 2=Community location; 3=at care institution
24	In total, how much sessions were included in the intended treatment?	Round number
25	In total, how much sessions did you complete? This includes both sessions provided face-to-face and online.	Round number
26	How many online sessions did you complete?	Round number
27	If you stopped treatment prematurely, what were the reasons to end the therapy and not finish all sessions as intended?	A. For technical reasons: 1=I had problems with my internet connection and/or my computer was not functioning; 2=I don't have a computer; 3=I don't trust the online sessions are secure; 4=I don't have enough skills to follow the online sessions; 5=other; B. For personal reasons: 1=I forgot to attend the online sessions; 2=I ran out of time; 3=I was ill; 4=I had to work; 5=My family did not support me; 6=I did not want to share my personal information through the internet; 7=Other; C. for therapeutic reasons: 1=I am not convinced that the therapy solves my problems; 2=the healthcare professional and the I came to the conclusion it had no use for the patient to continue treatment; 3=my mental problems are alleviated; 4=other

G.2 ccVC

Only applicable if the data is not available in the ROM or in the treatment platform.

Pre-treatment

Indicator	Question	Unit / categories
96	What is your age?	Number of years from birth
97	What is your gender?	1=Male; 2=Female
98	What is the highest level of education you received and completed?	1=Primary; 2=Secondary; 3=Higher and/or University; 4=Other
99	Did you or one of your parents immigrate to the country you now reside?	1=Yes; 2=No
100	What is the postal code you currently reside in?	Postal code
101	Are you currently employed?	1=Yes; 2=No; 3=Not applicable

Post-treatment

Indicator	Question	Unit / categories
115	How many times did the patient use the ccVC system?	Round number
116	At what location has the patient accessed ccVC sessions?	1=Individual; 2=Community location; 3=at care institution
117	How many ccVC sessions are completed?	Round number
118	If you stopped treatment prematurely, what were the reasons to end the therapy and not finish all sessions as intended?	A. For technical reasons: 1=I had problems with my internet connection and/or my computer was not functioning; 2=I don't have a computer; 3=I don't trust the online sessions are secure; 4=I don't have enough skills to follow the online sessions; 5=other; B. For personal reasons: 1=I forgot to attend the online sessions; 2=I ran out of time; 3=I was ill; 4=I had to work; 5=My family did not support me; 6=I did not want to share my personal information through the internet; 7=Other; C. for therapeutic reasons: 1=I am not convinced that the therapy solves my problems; 2=the healthcare professional and the I came to the conclusion it had no use for the patient to continue treatment; 3=my mental problems are alleviated; 4=other

Appendix H: Healthcare professional questionnaire

H.1 cCBT (preceding focus group discussions)

Indicator	Question	Unit / categories
7	What is the gender of the healthcare professional providing the treatment?	1=Male; 2=Female
8	What is the official profession of the healthcare professional providing the treatment?	1=GP; 2=Licensed psychologist; 3=Psychologist in training under supervision; 4=Psychologist with completed basic training; 5=Psychiatrist; 6=Psychiatrist with informal training in CBT; 7=Psychiatrist with a diploma in CBT; 8=Psychiatrist with a master; 9=Psychiatrist with a doctorate; 10=Mental health worker or community location staff; 11=Central administrator; 12=Other
9	In years, how much experience has the healthcare professional in mental health care?	1=less than 3 years; 2=3 years or more but less than 5 years; 3=5 years or more, but less than 10 years; 4=10 years or more
10	How many times did the healthcare professional provide a patient with cCBT or refer a patient to cCBT?	1=0-4 times, 2=5-9 times, 3=10-14 times, 4=15-19 times; 5=more than 20 times.
11	At the moment, is the healthcare professional trained for providing cCBT?	1=Yes; 2=No
71	On average, how many clients do you weekly see?	Number
72	Is your employment full-time or part-time?	1=Full time; 2=Part time for 0.## FTE
73	What proportion of your work is devoted to care related activities but not providing the actual treatments? Examples are case management, administrative tasks, etc.	Percentage

H.2 ccVC (preceding focus group discussions)

Indicator	Question	Unit / categories
102	What is the gender of the healthcare professional providing the treatment?	1=Male; 2=Female
103	What is the official profession of the healthcare professional providing the treatment?	1=GP; 2=Licensed psychologist; 3=Psychologist in training under supervision; 4=Psychologist with completed basic training; 5=Psychiatrist; 6=Psychiatrist with informal training in CBT; 7=Psychiatrist with a diploma in CBT; 8=Psychiatrist with a master;

		9=Psychiatrist with a doctorate; 10=Mental health worker or community location staff; 11=Central administrator; 12=Other
104	In years, how much experience has the healthcare professional in mental health care?	1=less than 3 years; 2=3 years or more but less than 5 years; 3=5 years or more, but less than 10 years; 4=10 years or more
105	How many times did the healthcare professional use ccVC services before?	1=0-4 times, 2=5-9 times, 3=10-14 times, 4=15-19 times; 5=more than 20 times
162	On average, how many clients do you weekly see?	Number
163	Is your employment full-time or part-time?	1=Full time; 2=Part time for 0.## FTE
164	What proportion of your work is devoted to care related activities but not providing the actual treatments? Examples are case management, administrative tasks, etc.	Percentage

Appendix I: Mental healthcare organisation Questionnaire

I.1 cCBT (preceding structured interviews)

Indicator	Question	Unit / categories
68	Approximately, how many units or departments can be distinguished in your organisation?	Round number
69	Approximately, how many FTE are currently employed at your organisation?	FTE
70	In what year is your organisation officially been established?	year
60	If you need to estimate, how much additional time of supportive functions is needed to support healthcare professionals to implement cCBT in their daily routine?	Time in FTE
61	In total, how much is invested in ICT infrastructure to be able to implement cCBT in the daily practice of the organisation?	Costs in euro
62	Did the users of the system receive a dedicated training? If so, what training did they receive and if not, why not?	Yes, no, why
63	What are the direct costs such as licenses, service level agreements, and maintenance and ICT infrastructure?	Costs in euro
64	What are the costs spend on overheads such as office rent, gas, heating/cooling, administration, etc.? Or: what percentage of the total costs normally is spend on overheads?	Costs in euro

I.2 ccVC (preceding structured interviews)

Indicator	Question	Unit / categories
159	Approximately, how many units or departments can be distinguished in your organisation?	Round number
160	Approximately, how many FTE are currently employed at your organisation?	FTE
161	In what year is your organisation officially been established?	year
151	If you need to estimate, how much additional time of supportive functions is needed to support healthcare professionals to implement ccVC in their daily routine?	Time in FTE
152	In total, how much is invested in ICT infrastructure to be able to implement ccVC in the daily practice of the organisation?	Costs in euro
156	Did the users of the system receive a dedicated training? If so, what training did they receive and if not, why not?	Yes, no, why
154	What are the direct costs such as licenses, service level agreements, and maintenance and ICT infrastructure?	Costs in euro
155	What are the costs spend on overheads such as office rent, gas, heating/cooling, administration, etc.? Or: what percentage of the total costs normally is spend on overheads?	Costs in euro

Appendix J: Interview Guide

J.1 Focus group discussions - cCBT

The focus group discussion intents to assess the barriers and facilitators to using cCBT in practice. It may be used to explore:

- Safety issues related to using cCBT.
- Reasons for dropout of patients from the intervention.
- Organisational aspects such as leadership engagement, implementation strategies, resources for innovation, attitude towards the interventions, perceived innovation climate, et cetera.
- Socio, ethical and legal aspects such as guidelines and professional liability.

Participants: healthcare professionals involved in delivering cCBT in the context of the MasterMind project can be selected as participants in the focus group. Ideally participants should reflect a range of ages, levels, and care setting.

Participant Consent: Participants will sign a consent form to participate in the focus group discussion. One copy of the informed consent form should be given to participants and the focus group facilitator should keep a second copy. Participants should be informed if any audiotaping is being used for data collection.

Demographic data: It is important to collect anonymous demographic data from focus group participants. Simple questionnaires for this purpose could be handed out as participants arrive, then collected at the end of the focus group and kept with the tapes of the focus group.

Facilitator/Moderator: Running an effective focus group is a skill and requires planning. Tips and guidelines for will be developed in due time.

Discussion guide: A discussion guide (see below) may facilitate structuring the focus group discussion by highlighting the topics that need to be covered. Though it is not to be used rigidly, like a questionnaire. At the focus group discussion, the facilitator encourages participants to explore topics in depth, to reflect, to raise their own issues, etc.

Data collection: The discussions can be audiotaped if agreed by participants, and transcribed verbatim and translated to English for analysis. Correctness of translation will be checked by forward-backward translation. The recordings need to be securely stored until transcribed and then destroyed. The transcription shall not contain information that would allow individuals to be linked to specific statements.

Time and Place for Focus Group: The focus group can last about one hour. Participants need to receive clear details of where and when the focus group will take place and how long it will last.

Discussion template: The template below provides a guide on how to proceed with conducting the technique and on the type of questions to be covered in the discussion.

Date and time:	Place of interview:
1. General information	
Tell a little bit about your experience with depressed patients and their treatment.	
Do you have experience with using cCBT?	
Tell about the last depressed person you had in your office (including contact, actions...)	
2. Safety of cCBT	
Indicator 15a	Since part of the treatment is delivered online, do you feel the treatment is safe for the patient? Why / why not?
Indicator 15b	What might be the risks to patients and how can this be overcome?

3. Reasons for Drop-out	
Indicator 28	In general, what were the reasons to not complete the therapy as intended?
4. Organisational aspects: leadership engagement	
Indicator 75	To what extent are your mangers or leaders engaged in implementing cCBT? How?
5. Organisational aspects: Implementation strategy	
Indicator 77	To what extent is made use of a dedicated Implementation Strategy? (Strategy that contains activities that are structured according to the following phases: planning, engaging, executing and evaluation); to what extend is it used and operationalised? Why?
6. Organisational aspects: resources for innovation	
Indicator 79	As a healthcare professional, are you allowed to spend extra time in treating clients with the intervention so you are able to implement it in your daily routine? Is it enough?
Indicator 80	Was therapists' time per patient treated affected after the implementation of cCBT/ccVC in their daily routine? If so, could you estimate by how much? (E.g. increase/decrease by X in the number of patients treated per day by a therapist)
Indicator 81	Have you observed any resource savings due to the implementation of cCBT/ccVC other than therapist's time? If so, could you estimate where and by how much?
7. Organisational aspects: when do you consider an implementation successful?	
Indicator 82	From your viewpoint, what are the most important factors that determine whether or not an implemented intervention is successful? How is this measured?
8. Organisational aspects: attitude	
Indicator 83	To what extent are you enthusiastic about using cCBT in treating your clients? What part the most and what the least?
9. Organisational aspects: confidence	
Indicator 84	To what extent do you feel confident in your own ability to use cCBT in treating your clients? What part the most, and what the least?
10. Organisational aspects: State of change	
Indicator 85	On the continuum of change, in what state are you currently?
11. Organisational aspects: Commitment	
Indicator 86	To what extent are you committed to the goals of your organisation?
Indicator 87	To what extent are you loyal to your organisation?
12. Organisational aspects: Support	
Indicator 88	To what extent do you feel supported and encouraged by your organisation in applying new and novel ways of working in your daily practice?
13. Organisational aspects: rewards	
Indicator 89	To what extent do you feel recognised by your organisation when incorporating a new intervention in your daily practice? How does this take place?
Indicator 90	How and to what extent do you feel appreciated in doing that?
14. Organisational aspects: relative priority	
Indicator 91	What priority do you give to implementing cCBT in your practice? Why?
15. Socio, ethical and legal aspects	
Indicator 92	How important are clinical guidelines in your organisation and how are they embedded / implemented in your organisation? Why or why not?
Indicator 93	Will the implementation of cCBT do well to our public image and in e.g. benchmarking? Why?
Indicator 94	Does intervention provides enough tools for me to bear my professional liability in counselling and treating the patient? How does this work?
16. Final questions	
Would you like to add anything? Anything I haven't asked, that you would like to elaborate?	
Thank you!	

J.2 Focus group discussions - ccVC

The focus group discussion intents to assess the barriers and facilitators of using ccVC in practice. It may be used to explore:

- Safety issues related to using ccVC.
- Reasons for dropout of patients from the intervention.
- Organisational aspects such as leadership engagement, implementation strategies, resources for innovation, attitude towards the interventions, perceived innovation climate, et cetera.
- Socio, ethical and legal aspects such as guidelines and professional liability.

Participants: healthcare professionals involved in delivering ccVC in the context of the MasterMind project can be selected as participants in the focus group. Ideally participants should reflect a range of ages, levels, and care setting.

Participant Consent: Participants will sign a consent form to participate in the focus group discussion. One copy of the informed consent form should be given to participants and the focus group facilitator should keep a second copy. Participants should be informed if any audiotaping is being used for data collection.

Demographic data: It is important to collect anonymous demographic data from focus group participants. Simple questionnaires for this purpose could be handed out as participants arrive, then collected at the end of the focus group and kept with the tapes of the focus group.

Facilitator/Moderator: Running an effective focus group is a skill and requires planning. Tips and guidelines for will be developed in due time.

Discussion guide: A discussion guide (see below) may facilitate structuring the focus group discussion by highlighting the topics that need to be covered. Though it is not to be used rigidly, like a questionnaire. At the focus group discussion, the facilitator encourages participants to explore topics in depth, to reflect, to raise their own issues, etc.

Data collection: The discussions can be audiotaped if agreed by participants, and transcribed verbatim and translated to English for analysis. Correctness of translation will be checked by forward-backward translation. The recordings need to be securely stored until transcribed and then destroyed. The transcription shall not contain information that would allow individuals to be linked to specific statements.

Time and Place for Focus Group: The focus group can last about one hour. Participants need to receive clear details of where and when the focus group will take place and how long it will last.

Discussion template: The template below provides a guide on how to proceed with conducting the technique and on the type of questions to be covered in the discussion.

Date and time:	Place of interview:
1. General information	
Tell a little bit about your experience with depressed patients and their treatment.	
Do you have experience with using ccVC?	
Tell about the last depressed person you had in your office (including contact, actions...)	
2. Safety of ccVC	
Indicator 108a	Since part of the treatment is delivered online, do you feel the treatment is safe for the patient? Why / why not?
Indicator 108b	What might be the risks to patients and how can this be overcome?
3. Reasons for Drop-out	
Indicator 118	In general, what were the reasons to not complete the therapy as intended?

4. Organisational aspects: leadership engagement	
Indicator 166	To what extent are your mangers or leaders engaged in implementing ccVC? How?
5. Organisational aspects: Implementation strategy	
Indicator 168	To what extent is made use of a dedicated Implementation Strategy? (Strategy that contains activities that are structured according to the following phases: planning, engaging, executing and evaluation); to what extend is it used and operationalized? Why?
6. Organisational aspects: resources for innovation	
Indicator 170	As a healthcare professional, are you allowed to spend extra time in treating clients with the intervention so you are able to implement it in your daily routine? Is it enough?
7. Organisational aspects: when do you consider an implementation successful?	
Indicator 172	From your viewpoint, what are the most important factors that determine whether or not an implemented intervention is successful? How is this measured?
8. Organisational aspects: attitude	
Indicator 173	To what extent are you enthusiastic about using ccVC in treating your clients? What part the most and what the least?
9. Organisational aspects: confidence	
Indicator 174	To what extent do you feel confident in your own ability to use ccVC in treating your clients? What part the most, and what the least?
10. Organisational aspects: State of change	
Indicator 175	On the continuum of change, in what state are you currently?
11. Organisational aspects: Commitment	
Indicator 176	To what extent are you committed to the goals of your organisation?
Indicator 177	To what extent are you loyal to your organisation?
12. Organisational aspects: Support	
Indicator 178	To what extent do you feel supported and encouraged by your organisation in applying new and novel ways of working in your daily practice?
13. Organisational aspects: rewards	
Indicator 179	To what extent do you feel recognised by your organisation when incorporating a new intervention in your daily practice? How does this take place?
Indicator 180	How and to what extent do you feel appreciated in doing that?
14. Organisational aspects: relative priority	
Indicator 181	What priority do you give to implementing ccVC in your practice? Why?
15. Socio, ethical and legal aspects	
Indicator 182	How important are clinical guidelines in your organisation and how are they embedded/implemented in your organisation? Why or why not?
Indicator 183	Will the implementation of ccVC do well to our public image and in e.g. benchmarking? Why?
Indicator 184	Does intervention provides enough tools for me to bear my professional liability in counselling and treating the patient? How does this work?
16. Final questions	
Would you like to add anything? Anything I haven't asked, that you would like to elaborate?	
Thank you!	

J.3 Structured interviews - cCBT

The structured interview intents to assess the barriers and facilitators of using cCBT in practice. It may be used to explore:

- Leadership engagement in changing routine practice
- Perceived success of implementation projects
- Role of clinical guidelines and external branding in innovating routine practice

Participants: eligible interviewees are representatives of mental healthcare organisations that are involved in MasterMind and have substantive budgetary decision power.

Participant Consent: Participants will sign a consent form to participate in the interviews. One copy of the informed consent form should be given to participants and the focus group facilitator should keep a second copy. Participants should be informed if any audiotaping is being used for data collection.

Demographic data: It is important to collect anonymous demographic data from focus group participants. Simple questionnaires for this purpose could be handed out as participants arrive, then collected at the end of the interview and kept with the tapes of the interview.

Interviewer: interviewing is a skill and requires planning and specific techniques. Tips and guidelines for will be developed in due time.

Interview guide: An interview guide (see below) for a structured interview standardises the questions and answers in the same order. Interviewers read the questions exactly as they appear on the survey questionnaire. The choice of answers to the questions is a combination of fixed (close-ended) and open-ended questions. A structured interview also standardizes the order in which questions are asked of survey respondents, so the questions are always answered within the same context.

Data collection: The interview can be audiotaped if agreed by participants, and transcribed verbatim and translated to English for analysis. Correctness of translation will be checked by forward-backward translation. The recordings need to be securely stored until transcribed and then destroyed. The transcription shall not contain information that would allow individuals to be linked to specific statements.

Time and Place for Focus Group: The interview can last about 30 minutes, and can have breaks in between for refreshments. Participants need to receive clear details of where and when the interview will take place and how long it will last.

Interview template: The template below provides a guide on how to proceed with conducting the technique and on the type of questions to be covered in the interview.

Date and time:	Place of interview:
1. Sustainability	
Indicator 65	Based on the findings in the study, is a business case for deciding whether or not to retain and maintain the intervention in the organisation? Why? What are the long-term effects? Probability of maintained;
Indicator 66	Is there adequate funding for maintenance of the intervention? What funding strategies are in place? How is reimbursement arranged for? Reimbursement systems changed?
Indicator 67	What are the most important reasons for keeping the service implemented in the organisation?
2. Leadership engagement	
Indicator 74	To what extent is the management engaged in implementing cCBT? How?
Indicator 76	To what extent is made use of a dedicated Implementation Strategy? (Strategy that contains activities that are structured according to the following phases: planning, engaging, executing and evaluation); to what extend is it used and operationalized? Why?
3. Resources	
Indicator 78	Are the healthcare professionals in your organisation allowed to spend extra time in treating clients with the intervention so you are able to implement it in your daily routine? Is it enough?

4. Successful implementation	
Indicator 82	From the organisation's viewpoint, what are the most important factors that determine whether or not an implemented intervention is sustained in the organisation and why? How is this measured?
5. Clinical guidelines	
Indicator 93	How important are clinical guidelines in your organisation and how are they embedded/implemented in your organisation? Why or why not?
6. Public image and benchmarking	
Indicator 94	Will the implementation of cCBT do well to your public image and in e.g. benchmarking? Why?
7. Professional liability	
Indicator 95	Does intervention provide enough tools for me to bear the organisation's professional liability in counselling and treating patients? How does this work?
8. Final questions	
Would you like to add anything? Anything I haven't asked, that you would like to elaborate?	
Thank you!	

J.4 Structured interviews - ccVC

The structured interview intents to assess the barriers and facilitators of using ccVC in practice. It may be used to explore:

- Leadership engagement in changing routine practice
- Perceived success of implementation projects
- Role of clinical guidelines and external branding in innovating routine practice

Participants: eligible interviewees are representatives of mental healthcare organisations that are involved in MasterMind and have substantive budgetary decision power.

Participant Consent: Participants will sign a consent form to participate in the interview. One copy of the informed consent form should be given to participants and the focus group facilitator should keep a second copy. Participants should be informed if any audiotaping is being used for data collection.

Demographic data: It is important to collect anonymous demographic data from focus group participants. Simple questionnaires for this purpose could be handed out as participants arrive, then collected at the end of the interview and kept with the tapes of the interview.

Interviewer: interviewing is a skill and requires planning and specific techniques. Tips and guidelines for will be developed in due time.

Interview guide: An interview guide (see below) for a structured interview standardises the questions and answers in the same order. Interviewers read the questions exactly as they appear on the survey questionnaire. The choice of answers to the questions is a combination of fixed (close-ended) and open-ended questions. A structured interview also standardizes the order in which questions are asked of survey respondents, so the questions are always answered within the same context.

Data collection: The interview can be audiotaped if agreed by participants, and transcribed verbatim and translated to English for analysis. Correctness of translation will be checked by forward-backward translation. The recordings need to be securely stored until transcribed and then destroyed. The transcription shall not contain information that would allow individuals to be linked to specific statements.

Time and Place for Focus Group: The interview can last about 30 minutes, and can have breaks in between for refreshments. Participants need to receive clear details of where and when the interview will take place and how long it will last.

Interview template: The template below provides a guide on how to proceed with conducting the technique and on the type of questions to be covered in the interview.

Date and time:	Place of interview:
1. Sustainability	
Indicator 65	Based on the findings in the study, is a business case for deciding whether or not to retain and maintain the intervention in the organisation? Why? What are the long-term effects?
Indicator 66	Is there adequate funding for maintenance of the intervention? What funding strategies are in place? How is reimbursement arranged for?
Indicator 67	What are the most important reasons for keeping the service implemented in the organisation?
2. Leadership engagement	
Indicator 165	To what extent is the management engaged in implementing ccVC? How?
Indicator 167	To what extent is made use of a dedicated Implementation Strategy? (Strategy that contains activities that are structured according to the following phases: planning, engaging, executing and evaluation); to what extend is it used and operationalized? Why?
3. Resources	
Indicator 169	Are the healthcare professionals in your organisation allowed to spend extra time in treating clients with the intervention so you are able to implement it in your daily routine? Is it enough?
4. Successful implementation	
Indicator 171	From the organisation's viewpoint, what are the most important factors that determine whether or not an implemented intervention is sustained in the organisation and why? How is this measured?
5. Clinical guidelines	
Indicator 182	How important are clinical guidelines in your organisation and how are they embedded/implemented in your organisation? Why or why not?
6. Public image and benchmarking	
Indicator 183	Will the implementation of cCBT do well to our public image and in e.g. benchmarking? Why?
7. Professional liability	
Indicator 184	Does intervention provide enough tools for your organisation to bear professional liability in counselling and treating patients? How does this work?
8. Final questions	
Would you like to add anything? Anything I haven't asked, that you would like to elaborate?	
Thank you!	

Appendix K: Contact information implementation sites and local investigators

Listed in alphabetical order of country and region.

K.1 Denmark

Name of institution	Telepsykiatrisk Centre, Internetpsykiatrien
Street address and phone	Sønder Boulevard 29 5000 Odense C, Denmark +45 20187263
Principal investigator	Kim Mathiasen, Project leader kim.mathiasen@rsyd.dk

K.2 Estonia

Name of institution	Cognuse OÜ
Street address and phone	Valge 13, Tallinn 11415, Estonia (+372) 6812025
Principal investigator	To be determined

K.3 Germany

Name of institution	Schoen Clinic Bad Arolsen
Street address and phone	Hofgarten 10 34454 Bad Arolsen, Germany +49-5691-6238-0
Principal investigator	Christian Raible, Managing Director Schoen Clinic craible@schoen-kliniken.de

K.4 Greenland

Name of institution	Agency for Health and Prevention
Street address and phone	Postboks 1001, 3900 Nuuk, Greenland + 299 344000
Principal Investigator	Georg Gouliaev, Head of psychiatric services in Greenland gego@peqqik.gl

K.5 Italy - Torino

Name of institution	Azienda Sanitaria LocaleTorino TO3 - ASL TO3
Street address and phone	Via Martiri XXX Aprile 30 10093 Collegno (TO) - Italy +39 0114017230
Additional trial sites	ASL TO3, site of Rivoli - Via Piave 19 10098 Rivoli (TO) ASL TO3, site of Orbassano - Via Monti 4 10043 Orbassano (TO) ASL TO3, site of Pinerolo - Str.le Fenestrelle 72 10064 Pinerolo (TO) ASL TO3, site of Venaria/Pianezza - Piazza Costituente 1 10078 Venaria (TO) ASL TO3, site of Luserna San Giovanni - Viale De Amicis 73 10062 Luserna San Giovanni (TO) ASL TO3, site of Susa - Via Fell 5 - 10059 Susa (TO) ASL TO3, site of Avigliana/Giaveno-V. Monte Pirchiriano 5-10051 Avigliana (TO)
Principal Investigator	Pier Maria Furlan, MD, Professor and Chair of Psychiatry, Torino University piermaria.furlan@unito.it

K.6 Italy - Treviso

Name of institution	Azienda unita locale socio Sanitaria N9 Di Treviso
Street address and phone	Via Antonio Scarpa 9 31100 Treviso, Italy +39 (0)422 322010
Additional trial sites	Mental Health Center of Treviso Mental Health Center of Mogliano
Principal Investigator	Gerardo Favaretto, MD - Director of the Mental Health Department gfavretto@ulss.tv.it

K.7 The Netherlands

Name of institution	Nieuwe Valerius GGZ inGeest
Street address and phone	Amstelveensweg 589 Amsterdam, The Netherlands +31 20 7881880
Principal investigator	D.J.F. van Schaik, MD PhD, Psychiatrist a.vanschaik@ggzingeest.nl

K.8 Norway

Name of institution	Norwegian Center for Integrated Care and Telemedicine (NST)
Street address and phone	Forskningsparken, Sykehusv. 23. 9019 Tromsø, Norway +4777754030

Principal investigator	Nils Kolstrup, MD, advisor to NST, researcher at UiT Arctic University of Norway Nils.Kolstrup@telemed.no

K.9 Spain - Aragon

Name of institution	Servicio Aragonés de Salud (Sector Sanitario de Barbastro)
Street address and phone	Ctra Nacional 240 s/n Barbastro, Spain +34974249011
Principal Investigator	Dr. Juan Coll Clavero, Innovation and New Technologies Manager jcoll@salud.aragon.es

K.10 Spain - Basque Country

Name of institution	Osakidetza
Street address and phone	C/ Alava, nº45 01006 Vitoria - Gazteiz
Principal Investigator	Andrea Gabilondo, Psychiatrist andrea.gabilondocuellar@osakidetza.net

K.11 Spain - Catalonia

Name of institution	Badalona Serveis Assistencials (BSA)
Street address and phone	Plaça de Pau Casals nº1 Badalona - 08911 + 34 651041515
Principal Investigator	Jordi Ibañez, Chief Medical Officer jibanyez@bsa.cat

K.12 Spain – Galicia

Name of institution	Servizio Galego de Saude (SERGAS)
Street address and phone	Edificio Administrativo San Lázaro sn + 34881540054
Additional trial sites	EOXI A Coruña; AS Xubias 84, A Coruña EOXI Ferrol; Pardo Bazán s/n, Ferrol EOXI Lugo; San Cibrao s/n, Lugo EOXI Ourense; Ramón Puga Noguerol 54, Ourense EOXI Pontevedra; Montecelo s/n, Pontevedra EOXI Santiago de Compostela; Travesía da Choupana s/n, A Coruña EOXI Vigo; Pizarro 22, Vigo
Principal Investigator	Manuel Arrojo Romero, Chief of Mental Health and Drug Addiction Division of the Galician Health Service; manuel.arrojo.romero@sergas.es

K.13 Turkey

Name of institution	Informatics Institute, Middle East Technical University METU
Street address and phone	Üniversiteler Mahallesi Dumlupınar Bulvarı No:1 06800 Çankaya Ankara/TURKEY +90 312 2107872
Additional trial sites	METU Medical Center, 06531 Çankaya Ankara/TURKEY Ayna, Clinical Psychology Support Unit, OdtuKent 1605/2, METU, Çankaya Ankara/TURKEY
Principal Investigator	Didem Gökçay, Program coordinator dgokcay@metu.edu.tr

K.14 United Kingdom - Scotland

Name of institution	Scottish Centre for Telehealth & Telecare, NHS 24
Street address and phone	NHS 24 East Contact Centre, Norseman House, 2 Ferrymuir, South Queensferry, EH30 9QZ, UK +447990514646
Principal investigator	Dr Stella Clark, Clinical Lead for Mental Health, NHS 24 stellaanne.clark@nhs.net

K.15 United Kingdom - Wales

Name of institution	Powys teaching Health Board
Street address and phone	Powys tHB Headquarters, Mansion House Bronllys, Brecon, Powys +44 1874 711661
Trial sites	Bryntirion Resource Centre, Welshpool Hospital, Gungrog Road, Welshpool Brohafren Resource Centre Back Lane Newtown Hazels Resource Centre, Temple Street, Llandrindod Wells Ty Illtydd, Bridge Street, Brecon The Larches Community Mental Health Center, Ystradgynlais Defynnog Ward Bronllys Hospital
Principal Investigator	Harold Proctor. Programme Coordinator Harold.proctor@wales.nhs.uk