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ImpleMentAll

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This document details a general description of all involved implementation sites covering the iCBT service that is implemented, specific implementation objective(s), the current/usual implementation activities, information on stakeholders involved in the provision of the service and in the implementation work and the site's specific planning for the implementation work.

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Executive Summary

This document contains a general description of all involved implementation sites covering the iCBT service that is implemented, specific implementation objectives, the current (usual) implementation activities, information on stakeholders involved in the provision of the service and in the implementation work and the site's specific planning for the implementation work.

The ImpleMentAll project (IMA) aims to gain knowledge on tailored implementation strategies and their outcome to enhance the efficiency of the implementation of eHealth interventions. While recent research has shown that iCBT can be effective for the prevention and treatment of depression, the implementation of these services is lagging. Here, it becomes clear that current implementation effort often is slow and costly. Therefore, there is a need for effective strategies for implementing iCBT in local mental health systems.

Tailored implementation strategies will be developed and tested for 12 different implementation sites, their mental health contexts and iCBT services. This document on the implementation sites of the ImpleMentAll project aims to give a detailed description on the iCBT solutions being implemented, depict the clinical context, the services are implemented into, and the status of implementation goals and plans of the participating implementation sites.

All services follow the principles of Cognitive Behavioural Therapy (CBT) and can thereby be considered evidence-informed, internet-based CBT treatments (iCBT), which safeguard high-quality treatment. Concurrently, they have been adapted to the local needs and restraints regarding the form of guidance, number of OTMs and duration of the treatment. These clinical contexts not only differ by their economic parameters, mental health care systems and legislations regarding eMental Health.

Additionally, participating implementation sites took decisions with regard to where in the local clinical context to implement the service (primary or secondary care), based on the local needs and capabilities. The clinical contexts can best be described by involved parties (persons and organisations) in service delivery and implementation. Most sites are involving psychologists in their services, some also psychotherapists and psychiatrists as well as specialised nurses in the service delivery. Referral is heavily based on either GP networks, self-referral or the support of health insurance companies. Within the implementation process, most trial site's implementation teams consist of managers and project employees within not only the participating organisations themselves, but also their GP network, local governments, insurance companies and universities.

Regarding the target groups of the clinical service, all implementation sites will be targeting adults suffering from either depression or anxiety (including somatic disorders). Additionally, the document highlights potential risks which are identified and analysed elsewhere, as this analysis goes beyond the scope of the implementation plans as such.

Finally, it became clear that most implementation sites lacked an elaborate or structured strategy for implementing the iCBT service. We assume that there is a need for effective implementation strategies and especially *tailored* implementation strategies fitting the clinical context and service implemented.

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1. INTRODUCTION

The ImpleMentAll project (IMA) aims to gain knowledge on tailored implementation strategies and their outcome to enhance the efficiency of the implementation of eHealth interventions.

While depression and anxiety disorders rank among the most prevalent disorders and put a severe economic burden on nations, many of those affected stay untreated and, despite the proven effectiveness of Cognitive Behavioural Therapy, the provision of evidence based treatments constitutes a constant challenge in the health care systems. Barriers include the shortage of (trained) providers or the inadequacy of treatment.

Using internet-based Cognitive Behavioural Therapy (iCBT) could help overcome some of the limitations of traditional treatments by increasing the accessibility of the treatment or attracting people who would not make use of a traditional service. While recent research has shown that iCBT can be effective for the prevention and treatment of depression, the implementation of these services is lagging behind. Here, it becomes clear that current implementation effort often is slow and costly. Therefore, there is a need for effective strategies for implementing iCBT in local mental health systems. We assume that there cannot be one implementation strategy fitting all existing implementation efforts.

Consequently, the IMA project aims to develop a toolkit to apply tailored implementation strategies in various mental health contexts and iCBT services. This ItFits-toolkit will provide implementers not only with evidence-based methods and tools, but also with contents, i.e. science-based knowledge on barriers and facilitators, implementation strategies, and evaluation framework.

This document contains a general description of all involved implementation sites covering the iCBT service which is implemented, information on stakeholders involved in the provision of the service and in the implementation work, the current (usual) implementation activities and the site's specific planning for the implementation work as well as the implementation objectives. The document is part of work package fives effort on implementation management.

1.1 Purpose of this document

To grasp the structure of the different trial sites and their implementation work, we will answer three major questions within this document, as to *what* service is implemented into which context (*where*), the process by which this is achieved at the moment (*how*) and, additionally, *what* implementation activities are planned for the future.

Here, we will analyse the whole implemented service, not only comprising of the implemented intervention or treatment but rather including the complete setup and involved procedures. Therefore, the clinical services will be described as to targeted groups, delivery details (e.g. who delivers the service, number of online treatment modules (OTM), technical solution used etc.) and therapeutic principles. An online treatment module

herewith is defined as one thematic entity of the treatment delivered internet- or mobile based.

Afterwards, the position in health care system, the patient flow and entry way into the iCBT service as well as involved persons and organisations in delivery of the service will be described. Moreover, implementation plans, goals and measures of success will be evaluated and planned activities and time plans will be provided. Data was assessed in a standardised format via a questionnaire and then confirmed during deepening interviews.

The information will assure the management of sites at the start of the project, as well as at the start of the trial, and assess the risks of the partners not fulfilling trial requirements at trial start. Furthermore, the information will feed directly into the project's work on data collection and management as well as the setup of the tailored implementation strategies.

1.2 Structure of document

Section 2 will give an overview of the therapeutic services implemented in the IMA project. Detailed descriptions of the different services will be provided, target groups described and the roots of entry to the service depicted. Furthermore, details on the CBT-based therapeutic principles and approaches used by the trail site will be discussed.

Section 3 concerns the clinical context into which the service will be implemented such as the place the service takes in the local environment, involved parties and funding schemes.

Section 4 will then describe the implementation plans and goals of the specific trial sites.

1.3 Glossary

ANU	Australian National University
ASLTO3	Azienda Sanitaria Locale TO3, Italy
BDI	Black Dog Institute
BSA	Badalona Serveis Assistencials SA
CBT	Cognitive Behavioural Therapy
CMHC	Community Mental Health Center
CMHTir	Community Centre for Health and Wellbeing
DF	German Depression Foundation
EAAD	European Alliance Against Depression
FFM	Fondation FondaMental
GET.ON	Get.On Institut
GiG	STICHTING GGZinGeest
GP	General Practitioner
GP-MHW	General Practitioner Mental Health Worker
IMA	ImpleMentAll
iCBT	Internet-based Cognitive Behavioural Therapy
iFD Tool	IFightDepression Tool
MDD	Major Depression Disorder

MHCPriz	Community Based Mental Health Center and House for Integration PRIZREN
n.a.	Not available
OTM	Online treatment module defined as one thematic entity of the treatment delivered internet- or mobile based
PHNS	Primary Health Network
RSD	Region of Southern Denmark
SVLFG	Sozialversicherung für Landwirtschaft, Forsten und Gartenbau (Social Insurance Company for Agriculture, Forests and Gardening)
t.b.d.	To be decided
UMCG	University Medical Center Groningen

2. THERAPEUTIC SERVICE

All trial sites implemented iCBT solutions which are based on evidence-informed CBT principles. In a broad and global definition of CBT, the basic underlying assumption is that emotional problems are reinforced by maladaptive behavioural strategies and dysfunctional subjective interpretations of a given situation. Based on experimental research on how humans and animals acquire new behaviour patterns, CBT also assumes that dysfunctional behavioural and thought patterns are learned (conditioned) and therefore can be changed.

Another important assumption is that complete extinction of previously learned associations is tough, and certain triggers can reinforce or reawaken dormant associations, leading to relapse. Which is why relapse risk is high and you need to provide the patient with tools that he/she can use if such a relapse occurs. CBT also assumes that treatment greatly benefits from a transparent work relationship between therapist and patient with a common goal (alleviating the patient's symptoms and emotional distress). This means that the therapist or the self-help program acts as a coach or advisor and therefore shares knowledge about a certain condition or treatment in order to help the patient understand why a certain intervention is deemed needed, and to motivate the patient to change.

Therefore, any CBT service (whether it is delivered online or face-to-face) will typically involve the same key elements, which can include:

1. Psycho-education: information on depression and/or anxiety from a CBT perspective and the treatment rationale
2. Evidence-based behavioural techniques
3. Evidence-based cognitive restructuring
4. Some form of relapse prevention

Though based on common therapeutic principles, the therapeutic services implemented do vary in their nature between the trial sites as they are adapted to the local health care environments and the region's needs.

As the clinical benefit of CBT is clear, the IMA project will solely focus on the effectiveness of the implementation intervention and not primarily on the effectiveness of the service. All sites implement iCBT programs adhering to the above-mentioned CBT principals and adapt the therapeutic services to the local health care environment and region's needs.

The ImpleMentAll project is not about the decision to implement or not. In recognising participating sites' autonomy and responsibilities, sites have chosen for and are committed to implementing iCBT for reasons relevant to their needs and standards. This resulted in a common set of therapeutic principles that included the services that are implemented. In addition, sites are allowed to enrich their services with additional contents where needed.

All participating site commonly set up a financial plan, the allocation of staff, the clinical target group, the provisioning of safety measures, the procurement of the technical platform and the positioning of the service in the health care system. All sites adhere to the set-up of

an implementation and maintenance financial plan which is placed in the local health care environment (implementation into routine care) and/or the investing in the effort of transforming the routine care conditions in order to foster the routine care conditions for iCBT service in their local environment (innovation funds, selective contracts etc.). Furthermore, a decision has been made by the participating organisation to employ staff to provide the service, and the form of guidance and safety measures are clearly planned. Additionally, a decision has been made on the target group including the clinical condition (depression, anxiety), age sex, gender etc.

A clear vision on the place which the service takes in the clinical context exists based on the demand identified in the region. A clear plan lines out how patients and further health care providers can find out about the service and enrol into it within the local environment. Patients follow a clear track trough the service (patient flow).

2.1 Description of therapeutic service

The IMA project aims to evaluate the effectiveness of a tailoring toolkit (ItFits-toolkit) for developing tailored implementation strategies within the implementation of eMental Health services.

Within the IMA project, the implemented services range from self-guided iCBT (BSA, ANU, BDI, UMCG) to healthcare professional guided iCBT (DF, Get.On, RSD, ASLT03) and blended treatments (FFM, GiG, CMHTir, MHCPriz). More information is depicted in Table 1.

Table 1. Implemented services

SITE	THERAPEUTIC SERVICE
ASLTO3	Self-guided iCBT with support by iCBT trained Mental Health Professionals
BSA	Self-guided iCBT with support by iCBT trained nurses and Mental Health Professionals
DF	Healthcare Professional guided iCBT
FFM	Therapist guided iCBT (solely or as part of blended treatment)
GET.ON	iCBT with support by psychologists/psychotherapists
GIG	Therapist guided iCBT as part of blended treatment
RSD	Therapist guided iCBT
UMCG	Self-help online intervention, supported by GP-MHWs
CMHTIR	Healthcare Professional guided iCBT (prospective: solely and as part of blended treatment)
MHCPRIZ	Healthcare Professional guided iCBT (prospective: solely and as part of blended treatment)
ANU	Low-intensity (self-guided) iCBT
BDI	Online psychological assessment service with treatment recommendations, self-guided iCBT

The iCBT treatments implemented do vary in structure (e.g. number of sessions), duration and the way of provision (Table 2). The number of Online treatment modules (OTM) provided within the treatments ranges from six to 12 OTMs (MW = 8,2, SD = 1,8). Within blended treatment, 19 treatment sessions are given as a combination of ten face-to-face sessions and nine OTMs. The partners in Kosovo and Albania are in an implementation stage where they are collecting data within focus-group interviews with involved health care professions to involve them in the decision on the number of OTMs in the blended intervention.

The overall duration varies between two and 20 weeks depending on the number of OTMs and planned treatment intensity. All partners are using iCBT treatments implemented in and provided by their own organisation. All treatments are provided via an internet-based platform accessible through a protected website (see below for further information).

Table 2. Details on services provided

SITE	STRUCTURE	DURATION	PROVIDER	WAY OF PROVISION
ASLTO3	6 main OTMS, 1 (adult version) or 3 (youth version) additional OTMs.	About 6-9 weeks (adaptable to patients' needs)	Mental Health Outpatient Facilities of Unit Azienda Sanitaria Locale TO3	• Italian version of the iDF Tool[1] • Interactive website • Tool use is supported by trained healthcare professionals • Face-to-face session with a therapist is provided before and after the treatment
BSA	8 OTMs	8-9 weeks (suggested: 1 OTM per week)	Badalona Serveis Assistencials SA	• Platform "Super@ tu Depresión" • Support is given by an iCBT trained nurse • Support by Mental Health Specialists will be given in case of an exacerbation of the patients' symptoms
DF	6 main OTMS, 1 (adult version) or 3 (youth version) additional OTMS	About 8-12 weeks (adaptable to patients' needs)	German Depression Foundation	• German version of the iFD Tool • Interactive website • Tool use is guided by healthcare professionals who successfully completed an online training and who maintain contact with the patient
FFM	12 one-hour sessions 2 sessions per week within the first 2 weeks	10 weeks	Fondation FondaMental, Expert Centers for resistant Depression	• Service is provided online with support of a trained therapist • Internet-assisted CBT, delivered alone or in combination with ongoing antidepressant therapy
GET.ON	6-8 OTMs	6-8 weeks	Get.On Institut	• Online via Minddistrict platform

[1] For a description of the iFD tool see appendix 2

SITE	STRUCTURE	DURATION	PROVIDER	WAY OF PROVISION
				• "Intensive guidance" (weekly) is provided by psychologists/psychotherapists via telephone
GIG	10 weekly face-to-face sessions, alternating with 9 online sessions	16-20 weeks	eHealth@Mind	• Blended treatment[2] • Online training via Minddistrict platform (www.minddistrict.com) • Guided by trained therapists • Alternating face to face and online contacts
RSD	Assessment interview of 1,5 hours (via video-chat/telephone) 6-9 OTMs post-treatment assessment interview of 30 minutes	10-12 weeks	Clinic Internetpsykiatrien	• Online via Internetpsykiatrien • Guided by psychologists • Weekly or bi-weekly support • Support is given via telephone or a secure text-based module • Danish version of FearFighter and NoDep
UMCG	Number of exercises is personalized. Expected: about 8 self-help exercises (with average length of 2 weeks)	about 16 weeks	University Medical Center Groningen	• Online intervention "Master Your Symptoms" (MYSelf) • Personalized self-help exercises • Guided by GP-MHW
CMHTIR	t.b.d.	t.b.d.	Community Centre for Health and Wellbeing Tirana in collaboration with the Albanian Ministry of Health, 3 Mental Health Treatment centers and the EAAD	• Albanian version of the iFD tool • The Albanian version of the instrument will be provided by the EAAD • The service is expected to be guided by psychiatrists, psychologists, social workers and mental health nurses of Community Mental health Centers
MHCPRIZ	t.b.d.	t.b.d.	Community Centre for Health and Wellbeing	• Albanian version of the iFD tool

[2] For more information, please see Appendix 3

SITE	STRUCTURE	DURATION	PROVIDER	WAY OF PROVISION
			Prizren in collaboration with the EAAD and 4 Community Mental Health Centers	• The Albanian version of the instrument will be provided by the EAAD • The service is expected to be guided by psychiatrists, psychologists, social workers and mental health nurses of Community Mental health Centers
ANU	10-12 low-intensity sessions	2-4 weeks	Australian National University	• Online via Black Dog Institute research platform • Self-guided with reminders
BDI	Online symptom screening, consultation on treatment options, referral to suitable intervention	Initial assessment screening, monitoring via fortnightly emails for 18 weeks	• Black Dog Institute • MindSpot Clinic	• "StepCare" (provided by BDI): automated web-based psychological assessment program • Symptom screening: provided in general practices on a mobile tablet by the general practice staff • Referral into stepped care model based on the severity of a patients' symptoms by a GP • the stepped care model includes iCBT solutions provided by BDI and MindSpotClinic • Symptom monitoring via regular online assessment

2.2 Target Group

All implemented services target adults. There are no exclusions as to the sex of a participant. Some services target specific patient groups such as patients which did not respond to medication (FFM), only members of specific health insurers (Get.On) or being situated in a specific region (RSD, ANU). Please see Table 3.

All implemented iCBT treatments are iCBT treatments for depression or anxiety disorders (including somatic disorders). Some partners extend their services also to substance abuse or suicidality. Additionally, some services also specifically target people suffering from subclinical symptoms or are subject to indicated prevention. The contra indications for treatment differ between the services and health care settings.

Table 3. Sites' target group

SITE	AGE	OTHER POPULATION CRITERIA	MENTAL HEALTH PROBLEM	CONTRA INDICATION
ASLTO3	≥ 18	Outpatients in treatment by GP's Patients treated by Mental Health Service	• Mild to moderate forms of MDD	• Obvious risk of suicide • Low digital literacy
BSA	≥ 18	Not specified (iCBT program for long-term unemployed people is planned)	• Mild to moderate forms of MDD	• Severe MDD
DF	≥ 25 (adult version) 15-25 (youth version)	Outpatients in treatment by a GP, Medical Specialist or Psychotherapist	• Mild to moderate or subclinical forms of MDD • Dysthymia	• No email account • No internet-access • Severe depression or bipolar or psychotic disorders • Acute suicidal thoughts or behaviour • Substance abuse/ substance addiction. (Contra indication might also apply to patients with cognitive impairment or personality disorders)
FFM	20-60	Patients who failed to respond to antidepressant treatment	• Depression	• Comorbidities with obsessive-compulsive disorder, eating disorders, and substance-related disorders
GET.ON	≥ 18	Members of insurance company SVLFG with mild to moderate mental health problems	• stress • depressive symptoms • panic disorder • increased alcohol consumption • sleeping problems	Not specified
GIG	≥ 18	Not specified	• Depression • Anxiety disorders	• Low digital literacy • Patients not able to read or write on Dutch language
RSD	≥ 18	Patients proficient in spoken and written Danish language	• Depression • Anxiety disorders	• High levels of social complexity and/or comorbidity • Patients receiving other psychological treatment • Suicidal intent

SITE	AGE	OTHER POPULATION CRITERIA	MENTAL HEALTH PROBLEM	CONTRA INDICATION
		sufficient computer-skills and technical equipment		• Psychosis • Bipolar disorder • Alcohol abuse
UMCG	≥ 18	Primary care patients	• Mild to moderate, persistent somatic symptom disorder • Primary physical complaint: Pain, gastro-intestinal complaints or fatigue	• Referred to or currently treated in mental health care • Started of adjusted dosage of psychotropic medication • Presence of severe anxiety, depression, or presence of post-traumatic stress syndrome • Severe somatic symptom disorder that needs treatment in specialized mental health care • Pregnancy • Engaged in a legal procedure concerning disability-related financial benefits
CMHTIR	15-80	Not specified	Depression	Not specified
MHCPRIZ	15-80	Not specified	Depression	Not specified
ANU	≥ 18	Emphasis on early intervention	• Mild to moderate forms of MDD • Anxiety disorders • Suicidal ideation	• Recent suicide attempt • Psychosis • Bipolar Disorder
BDI	≥ 18	Patients attending one of ten general practices within the Sydney and South Eastern Sydney local health districts personal email address available	• MDD • Anxiety disorders • Alcohol abuse	Not specified

2.3 Roots of entry to the service

Within nine out of 12 participating sites, patients are referred by a general practitioner (GP). Within GiG, RSD and ANU, self-referral is one of the roots of entry or the main entry route. Some partners are also receiving referrals by other health care professionals such as psychologists and psychotherapists. Get.On is recruiting via the cooperating health care insurance company.

Table 4. Roots of entry to the service

SITE	ROOT OF ENTRY
ASLTO3	Patients will be recruited from multiple target settings (iCBT trained GPs, Psychiatrists and psychologists). Thus, patients will be recruited both in primary (e.g. GP clinics) and specialized (e.g. Mental Health outpatient services) settings within the area of Unit ASLT03. Potentially, also mental health centres outside of UnitASLT03 will be included. Inclusion criteria and patients' digital literacy are evaluated by a Mental Health Professional during the assessment of the patient.
BSA	Patients can get referred from any of BSA's different care settings (primary care, specialized care and intermediate care). In order to reduce the burden on GPs and Mental Health Specialists, all referrals are collected via the "Outpatient Activation Consultation", where a fulltime-employed, iCBT trained nurse conducts face-to-face assessment interviews, gives detailed information about the service and manages the inclusion.
DF	Patient accounts can only be created by healthcare professionals (Guides). Guides have to successfully complete an online training about the iFD Tool and pass an online exam. Health care professionals who successfully completed the iFD-Tool training offer the tool to suitable patients. Patients must be in regular treatment while using the tool. The decision about whether a patient is suitable for the program is made by the guide based on the use of their regular clinical measures. The online training and the iFD Tool are free of charge.
FFM	Patients will get recruited within the expert centres for resistant depression throughout the French territory. The centres have created a large network across the French territory reliant on close collaborations with mental health professionals (public/private psychologists, psychiatrists, nurses) and general practitioners who are actively engaged in the evaluation and management of depressed patients in everyday clinical practice.
GET.ON	Patients will be referred by the social insurance company SVLFG. Members with mental health problems are being identified by the insurance company and then referred to various services (Get.On Institute amongst others). Suitable patients will get a letter with information material and with a code granting access to the internet platform. Several questionnaires are used in order to determine the best treatment for a given patient. Once the treatment plan is compiled, a coach (psychologist/ psychotherapist) contacts the patient and a mutual decision about the future treatment is made.
GIG	Patients are mostly referred by therapists from GGZ inGeest who conduct a regular intake procedure. Some patients are also directly referred by their GP. In addition, another route is available through the website of eHealth@Mind. Patients may access the website themselves and create an account. The account then provides access to an individual treatment platform. Patients are invited to complete a triage questionnaire and some additional open-ended questions. Within two working days, a therapist assesses the application and provides a written personalized advice for the need for referral and treatment. This advice also incorporates whether blended care at the eHealth@Mind clinic is a suitable option and may serve as a base to discuss a referral from the GP. A referral from a GP is a necessary requirement for treatment.

SITE	ROOT OF ENTRY
RSD	Self-referral via www.internetpsykiatrien.dk. The website is located within the websites of the Mental Health Services of Southern Denmark. Most patients are invited to a video-based assessment interview with a psychologist. The result of the assessment determines the inclusion.
UMCG	GPs with access to MYSelf can register eligible patients with somatic symptom disorder. After registration, patients will be screened with regard to the in- and exclusion criteria using an online tool. If one or more exclusion criteria are met, patients are excluded from using MYSelf. If not, patients will be invited by the GP-MHW to start with MYSelf. Starting December 2017: Only GPs involved in UMCG's RCT for evaluating the effectiveness of MYSelf will have access to the MYSelf intervention until the RCT inclusion is finished.
CMHTIR	The iFD tool will be included in the services of three Community Mental Health Centres for evaluation and specialised treatment providing basic mental health services, such as psychiatric evaluation and counselling and psychological counselling for patients and their family members. Patients will refer themselves or get referred by their GP.
MHCPRIZ	The iFD tool will be included in the services of four Community Mental Health Centres for evaluation and specialised treatment that provides basic mental health services, such as psychiatric evaluation and counselling and psychological counselling for patients and their family members. Patients will refer themselves or get referred by their GP.
ANU	Patients will refer themselves via internet or will get referred by a clinician. In the past, online advertising has been used.
BDI	All patients who attend a specified general practice will be offered the mobile tablet in the waiting room, which is loaded with the internet-based StepCare service. After patients have provided their consent on the mobile tablet, they are screened for symptoms of depression and/or anxiety and alcohol use. Based on these results, the GP consults the patients about their treatment options and if required, refers them to low intensity iCBT, face-to-face psychological therapy, medication or referral to a psychiatrist or integrated care team. There are two options for a referral to an iCBt solution: If a GP recommends "myCompass", the patient completes a two-question survey and this information is transmitted electronically to Black Dog Institute. The patient's details from the StepCare service is integrated with the myCompass program to automatically create an account for the patient. The patient receives an email with a URL link for them to follow, if they choose to commence with myCompass. If a GP recommends the "MindSpot Clinic", the GP clicks on a link located in the StepCare recommendation report which opens up the MindSpot online referral form. The GP submits this form electronically, and the patient is subsequently contacted by the MindSpot Clinic via email. The patient is responsible for setting up their MindSpot account.

2.4 Therapeutic Principles

All iCBT treatments follow the principle of Cognitive Behavioural Therapy. The advantage here lies in the availability of evidence-based, highly structured treatment manuals as well as its focus on the training of strategies and specific behaviours. All sites have a safety

protocol in place following good clinical practice and local procedures. The CBT content may vary according to the targeted diagnosis (depression, panic disorder, somatoform disorder, OCD). Additionally, some treatments can be individualised more easily than others (standardized self-help versus blended treatment) also causing differences in treatment provided within one specific treatment. More individualised treatments may be shaped by the patient's needs or the professional's preferences.

More information on the therapeutic principles underlying the implemented iCBT treatments can be found in table 5.

Table 5. Therapeutic principles at the sites

SITE	THERAPEUTIC PRINCIPLES
ASLTO3	CBT with six main OTMs and 1-3 additional OTMs. For a detailed description of the iFD Tool see appendix 2. The Tool is designed to be an add-on to patients' regular treatment. The iFD Tool will also be used by patients in addition to psychopharmacological treatment or psycho-therapeutical treatment. Healthcare professionals (particularly psychologists) will provide remote support if needed.
BSA	CBT with eight OTMs 1. What is Depression? 2. How different activities affect our mood 3. Increasing pleasant activities. Additional information on healthy habits 4. How our thoughts affect our mood 5. Learning to change our negative thoughts 6. Learning to change our negative thoughts. Special Situations 7. Problem Solving 8. Looking to the future In a holistic approach, patients are empowered to take control over their lives through psycho-education, cognitive restructuring and behavioural techniques in order to manage life in a healthy adaptive way. Unconditional self-regard is extended in order to include the unconditional regard of others. Guidance is provided by the nurse assigned to the Outpatient Activation Consultation who will also be in charge of doing follow-ups. Overall, the service is self-guided with minimum contact with the involved Healthcare Professionals (Healthcare Professional who referred the patient and Outpatient Activation Consultation nurse).
DF	CBT with six main OTMs and 1-3 additional modules. For a detailed description of the iFD Tool see appendix 2. The Tool is designed to be an add-on to patients' regular treatment. Guidance is supposed to consist of mainly administrative and motivational support and can be delivered face-to-face in regular meetings or via telephone. There are no constraints for the intensity of guidance. Guides may integrate parts of the tool in their regular therapy.
FFM	Therapist-guided, iCBT will be delivered alone or in combination with ongoing antidepressant therapy according to the severity of depressive symptoms.
GET.ON	The service is delivered via the Minddistrict platform (www.minddistrict.com). All trainings are based on CBT and were all evaluated in randomized controlled trials. The Get.On Institute offers trainings for reducing stress, depression, problematic alcohol consumption, panic disorder and sleeping problems. Support is being provided by Psychologists and

SITE	THERAPEUTIC PRINCIPLES
	Psychotherapists using a treatment manual and is meant to be guidance through the training rather than therapeutic support. Within the SVLFG intervention, "intensive guidance" with weekly contacts will be provided.
GIG	eHealth@Mind offers blended treatment with alternating face-to-face and online sessions. The online sessions are delivered via the Minddistrict platform (www.minddistrict.com). Overall, there are about 200 OTMs available. All OTMs start with an explanation of the platform itself, then focus on psycho-education and motivational techniques and then proceed to behavioural techniques, exposure and/or responsive prevention. At a later stage, cognitive techniques are introduced. The last part of each treatment focuses on the future and on relapse prevention. OTMs may be adapted to a great extent on the basis of the therapist's own assessment of what is needed for the patient.
RSD	CBT with the core elements • psycho-education • behavioural activation • exposure (in-vivo and interoceptive) • cognitive restructuring • relapse prevention Each patient has a fixed therapist to refer to who conducts the assessment interview and who is available for weekly or bi-weekly support.
UMCG	The exercises within MYSelf contain elements of education, CBT, mindfulness, and Acceptance and Commitment Therapy. The number of exercises is personalised. Therefore, the intensity of the intervention depends on the specific patient and is tailored to the perpetuating factors of the patient's physical symptoms. The intervention is guided by a trained GP-MHW (psychologist or nurse working for a GP).
CMHTIR	CBT with six main OTMs and 1-3 additional OTMs. For a detailed description of the iFD Tool, see appendix 2. The Community Mental Health Centers consists of multi-disciplinary teams (psychiatrists, psychologists, social workers, art therapist) who will be trained to use the iFD tool. Presumably, a mixed approach will be pursued: A stand-alone version for people with mild depression and a blended- treatment version for people with moderate to severe depression.
MHCPRIZ	CBT with six main OTMs and 1-3 additional OTMs. For a detailed description of the iFD Tool see appendix 2. The Community Mental Health Centers consists of multi-disciplinary teams (psychiatrists, psychologists, social workers, art therapist) who offer a variety of care services (supportive psychotherapy, psychoeducation, home visits, recreational activities), and who will be trained to use the iFD tool. Presumably, a mixed approach will be pursued: A stand-alone version for people with mild depression and a blended- treatment version for people with moderate to severe depression.
ANU	Treatment is focused on CBT with elements of Dialectic Behavioural Therapy and Motivational Interviewing. The program is self-guided, but assessments are made to monitor the patients' symptoms.
BDI	The StepCare service consists of a sophisticated online assessment and personalised package of evidence-based psychological care that matches the patients' symptom levels. It provides GPs and patients with:

SITE	THERAPEUTIC PRINCIPLES
	1. An online psychological assessment tool designed to fit into the workflow of busy general practices, with results fed back to patients and seamlessly integrated into GP software, 2. Clinical treatment recommendations about individual patients for GPs to consider along with their own assessment of a patient's needs, regular monitoring of patients with feedback to patient and GP The iCBT programs recommended within the service for patients showing mild symptoms are: A self-guided program ("MyCompass", provided by BDI) and a clinician-guided program ("MindSpot Clinic"). Patients who screen in the moderate to severe symptom range are recommended face-to-face psychological therapy with or without medication.

Regarding the therapeutic approach underlying the iCBT service, two implementation sites are using a manual (Get.On and GiG). At all other implementation sites, no manuals are used for the provision of the treatment.

2.5 Technical solution

Several partners are using the same underlying treatment platform. The iFight Depression Tool is located in its own environment licensed by the European Alliance Against Depression. This tool is used by ASLTO3, the German Depression Foundation and the partners in Kosovo and Albania. Other partners are buying technical solutions to provide their content on, such as the Minddistrict platform (Get.On, GiG) or "Grip" (UMCG). Other partners possess their own platform (BSA, ANU, BDI).

Table 6. Technical solutions used at the sites

SITE	TECHNICAL SOLUTION
ASLTO3	**iFightDepression** (licensed by EAAD)
BSA	**Super @ tu Depresión** Programming language: ASP.NET coded in C# Output language: HTML/HTML5/Strict HTML User interaction: AJAX and Javascript Interoperability: Every device with a web browser
DF	**iFightDepression** (licensed by EAAD) Content management system: Contao 3.4.5 Hosted by domainfactory, administration by C2 mediaproduction Available in responsive design for usage on tablets and smartphones
FFM	Not specified
GET.ON	**Minddistrict**
GIG	**Minddistrict**, including video conferencing and message service
RSD	**NoDep** (Context Consulting ,DK) **FearFighter** (Context Consulting, DK)

SITE	TECHNICAL SOLUTION
UMCG	Platform "**Grip och Klachten**" ("Master Your Symptoms") Developed by UMCG, Nedap Healthcare (www.nedap-healthcare.com) and Roqua (www.roqua.nl) Roqua: Webbased testmanager, routine outcome monitoring application (integrated in MYSelf)
CMHTIR	**iFightDepression** (licensed by EAAD) to be managed online by the EAAD's technicians
MHCPRIZ	**iFightDepression** (licensed by EAAD) to be managed online by the EAAD's technicians
ANU	**Black Dog Institute research platform**
BDI	**Integrated online platform** Developed by Black Dog Institute University of New South Wales server

2.6 Communalities and differences

All services follow Cognitive Behavioural Therapy principles, while they are differing in the number of OTMs and overall treatment duration as well as the treatment modalities (e.g. form of guidance). Four partners (33.3%) are implementing self-guided iCBT treatments, four therapists guided iCBT (33.3%) and four blended treatments (33.3%).

The number of OTMs provided is varying between 6 and 12 (MW = 8,2, SD = 1,8). The duration of the treatment is severely dependent on the treatment setup and varies between two and 20 weeks (MW = 11 weeks; SD = 4,6). 75% (n= 9) of the implementation sites include GPs into their recruitment process, while three partners (25%) are relying on self-referrals as their main root of entry into the service. Additionally, referrals are made by other health care professionals or health insurance companies. Three partners (25%) own their own technical platform for the provision, while the others are working within third-party environments.

All implementation sites provide the iCBT service themselves in their own institution via an internet-based platform. All implemented services target adults suffering from depression or anxiety (including somatic disorder) and some implementation site limit their offer to a specific population group, such as insurant of a specific health insurance company or subjects to indicated prevention. Only two implementation sites are using a treatment manual.

While the form of guidance, number of provided OTMs and duration of the treatment is varying between the implementation sites, all implemented treatments follow common principles within the local health care context. Furthermore, the variety in services implemented will allow the project to assess implementation strategies for multiple iCBT services, meaning that the implementation strategies evaluated will not be dependent of the form of treatment.

3. Clinical Context

There is a great amount of variance in clinical contexts between the participating IMA sites. Within the project, iCBT services will be implemented in Italy, Spain, Germany, France, the Netherlands, Denmark, Kosovo, Albania and Australia. These countries differ regarding the economic status, the organisation of mental health care systems including reimbursement and legislation, amongst others.

In the following, the placement of the implemented iCBT service in the health care environment of the trial site will be described. Here, a distinction is made between primary and secondary care, primary care being defined as the first point of contact for anyone with a (mental) health issue. There, the GP (or assistant) can either treat or refer to specialist care. Secondary care, (including inpatient and outpatient), is including medical care provided by a specialist or facility upon referral by a primary care physician.

Then, a detailed description of persons and organisations involved in the service delivery and implementation will be given. Additionally, the founding plans will be defined.

3.1 Service placement in local environment

Services implemented are located at different points within the local health care system, wherever the need for the service was identified. ASLTO3, DF, UMCG and BDI locate their service mainly in primary care, while ANU considered its service as an adjunct to other health care services in primary care that can also be used as preventive care. FFM, RSD, CMHTir and MHCPriz are locating their implemented service mainly in secondary care. BSA and GiG target both primary and secondary care, while Get.On will be working mainly in the prevention sector.

Table 7. Location of the services within the local environment

SITE	SERVICE LOCATION
ASLTO3	Service is located within the Mental Health Outpatient Services of Unit ASLT03 (**primary care**).
BSA	The implementation of the iCBT intervention in Badalona comes as an extra treatment given to the Healthcare Professionals of any care setting (**primary and secondary/specialized care**) but with a main focus on primary care (referral by GPs).
DF	Mainly located in **primary care**. The iFD Tool could also be used to support transition from inpatient to outpatient treatment, for aftercare, between episodes of a depression, or to bridge waiting times.
FFM	The expert centers for resistant depressed represent relevant regional services at the boundary between **specialized/secondary-tertiary** care.
GET.ON	Trainings are mainly used as **preventive care.**
GIG	eHealth@Mind is an e-mental health clinic operating within GGZ inGeest, a large academic mental health organization serving the greater Amsterdam area. GGZ inGeest consists of several inpatient and outpatient divisions for various mental health disorders offered at two levels (**basic and specialized mental health care**).

SITE	SERVICE LOCATION
RSD	Internetpsykiatrien is situated in **secondary care** in the Mental Health Services of Southern Denmark within the Research and Development Department (Centre for Tele-Psychiatry).
UMCG	MYSelf will be used as a first treatment step in **primary care.**
CMHTIR	The Mental Health Community services are specialized services part of the **secondary health care system** service.
MHCPRIZ	The Mental Health Community services are part of the **secondary health care system.**
ANU	Adjunct to Healthcare Services in primary care; also used as preventive care.
BDI	The service is located as a first step in **primary care.**

Patient flow diagrams provided by partners are provided in Appendix 1.A from ASLTO3, 1.B from BSA and 1.C from DF, 1.D from UMCG, 1.E from CMHTir and 1.F from BDI.

3.2 Description of persons involved in service delivery and implementation

Almost all implementation sites involve psychologists in the delivery of their services. 75% (n=9) of the partners also involve GPs, not only in the referral but also in the delivery process. 67% (n=8) partners involve psychotherapists, and 58% (n=7) psychiatrists and the same number of partners involve specialised nurses. In the Netherlands, there is a special group of mental health professionals, "General Practitioner Mental Health Workers" (GP-MHW), which are mental health workers working in GP practices and being trained in the provision of the iCBT tool. Two partners, the German Depression Foundation and Australia's BDI are involving other medical specialists and three partners (ASLTO3, CMHTir and MHCPriz) are also involving social workers. ASLTO3 will also be involving professional educators. At all implementation sites, administrative employees and technical and IT support staff will be involved. For further details, please see below.

Table 8. Personnel involved in the service delivery

	ASLT03	BSA	DF	FFM	Get.On	GiG	RSD	UMCG	CMHTir	MHCPRIZ	ANU	BDI
Psychologists	X	X	X	X	X	X	X	-	X	X	X	X
Psychotherapists	X	X	X	X	X	X	-	-	-	-	-	X
Psychiatrists	X	X	-	X	-	X	-	-	X	X	-	X
Specialized nurses	X	X	-	X	-	X	-	-	X	X	-	X
GPs	X	X	X	-	-	X	-	X	X	X	X	X
Administrative staff	X	X	X	X	X	X	X	X	X	X	X	X
Technical and IT support staff	X	X	X	X	X	X	X	X	X	X	X	X

Table 9 describes the estimated number of involved persons and their role in the service delivery context.

The number of referrers involved in the service differs between the sites as, for example, RSD and ANU are relying on self-referrals and therefore do not include referrers in the process. Almost all other partners involve their patients via GP referrals, and the number of involved GPs ranges around 300 for the whole project now (excluding site that cannot give an estimate at the moment). Additionally, other mental health care workers, psychologists, psychiatrists and others will be involved in the referral process. For more details, please see table 9.

Regarding personnel involved in the delivery of the service, 50%, (n = 6) of implementation sites mention psychologists or psychotherapists (25%, n = 3) as being involved in service delivery. Four partners (33%) mention the involvement of a psychiatrist or medical specialist in service delivery and two (BSA, FFM) the involvement of a nurse. For UMCG, the service is also delivered by the abovementioned GP-MHW. It needs to be stated that the description “service delivery” is very much dependent on the treatment modality (e.g. technical or emergency support in a mainly self-guided intervention versus a blended treatment) and the profession of the described involved personnel will differ accordingly. The estimated number of persons involved in service delivery is about 290.

The organisation of implementation activities differs with regards to the specifics of the mental health context and therefore also the involved persons and organisations. For most trial sites, the team consists of managers and project employees and the estimated number of people involved in the actual implementation work at this moment of the project is 72.

Table 9. Persons involved in the local referral, service delivery and implementation

SITE	REFERRERS TO SERVICE (ESTM. #)	DELIVERERS OF SERVICE (ESTM. #)	IMPLEMENTING THE SERVICE (ESTM. #)
ASLTO3	• GPs (n.a.) • Psychiatrists (n.a.)	Psychologists (2-3)	ASLT03- team of the IMA project (6-7)
BSA	Healthcare Professionals (98)	Outpatient Activation nurse (with support) (1+98)	Nurse and technical staff (8)
DF	• GPs (49) • Medical specialists (15) • Psychotherapists (27) • Other (9)	• GPs (49) • Medical specialists (15) • Psychotherapists (27) • Other (9)	• iFightDepression core project team: (10) • Regional "Alliances Against Depression" (n.a.).
FFM	Mental health nurses, psychologists, psychiatrists (40 around each expert center)	Mental health nurses, psychologists, psychiatrists (2 around each expert center)	Not specified
GET.ON	Staff of social insurance company SVLFG (10-20)	Psychologists, psychotherapists (11)	Psychologists/managers (11)
GIG	• Psychotherapists (n.a.) • GPs (n.a.) • Administrative staff (n.a.)	• Psychotherapists (4) • Psychiatrist (1) • Specialized Mental Health Nurse (1)	• Management (2) • Data manager (1) • Marketing assistant (1)
RSD	Self-referral (0)	Clinical Psychologists (6)	Management (4)
UMCG	GPs (41)	GP-MHW (41)	Project leader, project coordinator, research staff (5)
CMHTIR	GPs, health promotion workers from primary health care centers (20)	Psychiatrists and psychologists from 3 Community Mental Health Centers in Tirana, SHkodra and Korca (10)	Staff of Community Mental Health Centers (10)
MHCPRIZ	GPs, health promotion workers from primary health care centers (20	Psychiatrists and psychologists from 4 Community Mental Health Centers in Prizren, Prishtina, Gjilan and Mitrovica (10)	Staff of Community Mental Health Centers (10)
ANU	Self-referral (0) (referral via pharmacies and GPs will be tested)	Self-guided (0)	Researchers of the ANU (n.a.)
BDI	GPs (60)	Practice Managers, primary health network mental health coordinators, Black Dog Institute StepCare Coordinators, MindSpot clinicians (25)	Black Dog Institute StepCare Coordinators, IT support staff, mental health professionals (5)

3.3 Description of organisations involved in service delivery and implementation

Regarding the organisations involved in the service delivery and implementation of the IMA project, more than half of the participating implementation sites name their GP network as a crucial part of the organisational setup. Additionally, in multiple regions, the local government is directly involved in the implementation process. Two partners (Get.On and GiG) state to include health care insurance companies into their organisational setup and three sites (Get.On, UMCG and ANU) involve university structures in the implementation process.

Table 10. Description of the involved organisations

SITE	ORGANISATION'S DESCRIPTION
ASLTO3	• Mental Health Outpatient Facilities • Mental Health Department • GPs network
BSA	• BSA as main organisation involved, integrated private health and social care organisation, provides the social care services for the region of Badalona and three other towns • City Council of Badalona
DF	• EAAD as administrative owner of the iFD program • Distribution via national member organisations for Germany via DF • Additional implementation work via pilot projects and co-operations with institutions interested in using iFD.
FFM	Not specified
GET.ON	• Minddistrict as platform provider • Universities (Leuphana University Lueneburg, University of Erlangen-Nuremberg) • Design Staff for Website and Prints • SVLFG: social insurance company • Various companies in various sectors, e.g. Telekom, Condor
GIG	• eHealth@Mind within GGZ inGeest • General practices • Social health insurance • Local government
RSD	• Clinic Internetpsykiatrien • Mental Health Services of Southern Denmark • Region of Southern Denmark
UMCG	• General practices throughout the Netherlands as implementation sites • University Medical Centre Groningen (UMCG), Department of Psychiatry: Coordination of implementation and service delivery for Roqua • Nedap Healthcare: Service delivery for MYSelf

SITE	ORGANISATION'S DESCRIPTION
CMHTIR	• General practices as paths of referral • Community Mental Health Centers
MHCPRIZ	• General practices as paths of referral • Community Mental Health Centers
ANU	• Currently ANU, primary care clinics will be added
BDI	• Black Dog Institute as provider of the StepCare service, and the iCBT program myCompass. • MindSpot Clinic as a free service providing online screening assessments and treatment courses • General Practices

The number of referring organisations varies depending on the referral mode: six partners use their GP network, four (additionally) rely on self-referral (therefore not including an additional organisation), three partners name the cooperating local mental health facility as referring organisation and one solely relies on the referral of the cooperating health insurance company.

At most trial sites, the involved mental health facility (e.g. clinic, institute) is named as the organisation delivering the service (while ANU's service is unguided and therefore not needing a deliverer). The organisation responsible for the implementation work is in most cases the mental health facility involved.

Funding schemes differ depending on the local situation, five partners receive funding from their cooperating mental health facility (e.g. clinic or institute). Three partners (GiG, RSD, ANU) are (or will be) receiving government funding. Two partners receive a reimbursement by the local health insurance system (GiG, Get.On), while UMCG is currently receiving funding via an innovation fund. ASLTO3 and FondaMental are solely dependent on the project funding.

Table 11. Organisations local referral, service delivery, implementation and funding

SITE	REFERRERS TO SERVICE (ESTM. #)	DELIVERERS OF SERVICE (ESTM. #)	IMPLEMENTING THE SERVICE (ESTM. #)	FUNDING THE SERVICE (ESTM. #)
ASLTO3	Mental Health Outpatient Facilities (11) GPs network (20)	Mental Health Outpatients Facilities (1-2)	Mental Health Department (1)	Grant of IMA Project (1)
BSA	BSA (1)	BSA (1)	BSA (1)	BSA (1)
DF	Unknown	Unknown	EAAD, DF (2)	• EAAD and partners • Deutsche Bahn Foundation • Project overhead income from projects that use the iFD Tool

SITE	REFERRERS TO SERVICE (ESTM. #)	DELIVERERS OF SERVICE (ESTM. #)	IMPLEMENTING THE SERVICE (ESTM. #)	FUNDING THE SERVICE (ESTM. #)
				(exact numbers unknown)
FFM	Not specified	Not specified	Not specified	Grant of IMA Project (1)
GET.ON	Social Insurance Company SVLFG (1)	GET.ON Institut (1) Technical partner Minddistrict (1)	GET.ON Institut (1)	Social insurance company SVLFG (1)
GIG	Mental health organizations (n.a.) General practices (n.a.)	eHealth@Mind within GGZ inGeest (1)	eHealth@Mind within GGZ inGeest (1)	• Social health insurance (n.a.) • Local government (n.a.) • GGz inGeest (1)
RSD	Self-referral (0)	Internetpsykiatrien (1)	Mental Health Services (1-2)	Region of Southern Denmark (1)
UMCG	General practices (30)	UMCG, Nedap Healthcare (2)	General practices (2) UMCG (1)	Innovatiefonds "Zorgverzekeraars" (1) (Planned in long term: health insurance companies)
CMHTIR	General practices and self-referral (20)	CMHCs (3)	CMHCs (3)	• Grant of IMA project • Community Center for Health and Wellbeing-Albanian Partner Organization (1)
MHCPRIZ	General practices and self-referral (20)	CMHCs (4)		• Grant of IMA project • CMHC Prizren (1)
ANU	Currently: self-referral (0) Planned: General practices (30), pharmacies (30)	Self-guided (0)	ANU (1)	ANU (1) (Future governmental funding possible)
BDI	General practices (20)	MindSpot and Black Dog Institute (2)	MindSpot and Black Dog Institute (2)	MindSpot and Black Dog Institute (2)

3.4 Communalities and differences

Most sites are involving psychologists in their services, some also involve psychotherapists and psychiatrists as well as specialised nurses. Additionally, all sites are involving administrative personnel and technical or IT support staff. For the service delivery, most partners involve psychologists or psychotherapists.

The service delivery is highly dependent on the treatment modality. The estimated number of persons in service delivery is 290 at this point of the project. For most trial sites, the team consists of managers and project employees and the estimated number of people involved in the actual implementation work at this moment of the project is 72.

Participating sites equally implement their services into primary or secondary care. The number of involved referrers depend on the referral mode. For the sites not relying on self-referrals, they include patients via GP referrals and the number of involved GPs ranges around 300 for the whole project now (excluding site that cannot give an estimate at the moment). Additionally, other mental health care workers, psychologists, psychiatrists and others will be involved in the referral process.

Organisations involved in the service delivery and implementation service include, besides the participating organisations themselves, their GP network, local governments, insurance companies and universities. Funding plans range from funding by the participating trial site, government funding, health care system reimbursement or the sole reliance on the project funding.

4. Implementation goals and plans

For the IMA project, we assume that the participating partners have decided that the implementation takes place and this process has been undertaken on the accurate political and management level.

The implementation sites present clear implementation objectives (e.g. to include a higher number of patients, increase the number of patients using the service, increase the number of therapists using the service, etc.) as well as ideas on how to achieve these objectives. All implementation sites share the common goal to increase access to their service and the number of patients treated.

These implementation plans and goals are depicted below for each partner and the communalities and differences are being discussed.

4.1 ASLTO3

ASLTO3 wishes to deploy the iCBT intervention in the routine clinical practice of the current Mental Health services. Therefore, primary objectives are: To reach a larger proportion of patients suffering from mood and/or anxiety disorders, to reduce the time required for a patient to get into treatment, to help individuals to self-manage their symptoms appropriately and to promote recovery.

The introduction of a large-scale iCBT service on the territory of the ASLT03 will allow a significant number of patients to benefit from treatment and allow to reach a larger number of patients at the onset of their depression.

Local Mental Health Services have already been enhanced and supported by iCBT-trained psychologists in order to deliver the iCBT solutions in a skilled way. Moreover, during the next year, promotion and dissemination campaigns at scientific events and conferences will be organised.

The success of the implementation activities could be measured through the level of acceptance and satisfaction of the Health Professionals involved, the patients' compliance to the iCBT solution and the sustainability of the implementation model.

Due to the validation of version two, the iFD Tool in Italian language is not active right now. It will be in reuse after September 2017.

4.2 BSA

BSA wishes to deploy the iCBT intervention in routine practice while increasing the quality of care provided for patients without putting any more burden than needed to clinical staff. Also, the number of patients and the number of sites involved are to be increased. In addition, the implementation of a preventive intervention for long-term unemployed people based on iCBT is planned. BSA will use the knowledge gained from previous projects and will put a lot of emphasis on the new instrument (the Outpatient Activation Consultation). Super@ tu

Depresión will be included in the Outpatient Activation Consultations' catalogue of services in September 2017 and the implementation will start in October 2017.

Measures of success would include whether a higher number of patients could be reached, whether patients and Healthcare Professionals are more satisfied, whether the adherence to the intervention is good and whether the service stays cost-effective.

4.3 DF

The German Depression Foundation wishes to increase the number of guides and patients using the system. In terms of implementing the tool, a broad network of regional alliances against depression is considered useful. DF also wishes to contribute towards stabilizing the reputation of eHealth-programs.

To achieve these goals, feedback from users via an accompanying evaluation tool will be used to continually improve the iFD tool. Also, a survey is to be set up among guides to find out more about their views on implementation. Co-operations with partners from research and with partners from the care sector and health insurances will be entered. iFD will be included in future projects and awareness will be raised using the network of the EAAD and the network of over 70 regional alliances all over Germany. Currently, flyers for healthcare professionals/GPs and patients are produced, as well as a poster for GP practices and clinics to support regional alliances in advocating the tool. A hotline for guides using the iFD tool was installed to support them with any questions and the implementation in general. The iFD tool will also be presented at conferences and meetings where care providers are present.

Announcements in journals/newspapers read by healthcare professionals have already been published and have shown some positive impact, especially regarding increased numbers of guides registered.

Measures of success would further include whether the iFD Tool is successful in becoming an established part of the EAAD's four-level approach intervention model.

4.4 FFM

Fondation FondaMental aims to disseminate iCBT firstly throughout the network of expert centers for resistant depression, and secondly throughout the French territory.

In order to achieve these goals, a suitable iCBT solution is to be found and to be implemented within the centers.

Measures of success would include the successful implementation of iCBT in every center for resistant depression accompanied with the inclusion of patients in each center.

4.5 Get.On

Get.On is working towards co-operations with more health insurances so that patients of various companies can benefit from internet-based treatment. Also, Get.On aims to have their trainings certified as medical devices and medical aid, so that GPs will be able to write

prescriptions for the trainings. In addition, more technical staff and IT developers will be employed in order to develop an own technical platform to deliver the iCBT service.

Overall, the number of patients and the number of Health Care Professionals involved are intended to be increased. To achieve these goals, Get.On will enter co-operations with research projects and improve marketing strategies.

Measures of success would include an increased number of employees, a higher turnover, an increased number of users, higher user engagement and an increased number of co-operations.

4.6 GiG

eHealth@Mind aims to upgrade the number of patients included in the service via GPs and self-referral. The total number of patients and of healthcare professionals involved will be increased. In order to deliver cost-effective treatments, the optimal mix of face-to face and online sessions within the blended treatment is to be explored, and better insights into target populations that would benefit the most from the treatment, or are attracted most to blended treatment, will be generated.

To achieve that, a system to use routine care data will be installed. Knowledge and experience on online treatment will be disseminated, first within the mother organization GGZ inGeest, then on a larger scale throughout the Netherlands.

Furthermore, a good working video-conferencing system for consultations to other professionals is needed, also in order to reach the target population in a more efficient way.
To achieve these goals, marketing strategies will be intensified and specified. A dashboard on the treatment data will be designed and training and super-/intervision programs will be installed.

Measures of success would include a higher number of overall referrals with a higher percentage of external referrals and self-referrals, good working monitoring on structural and incidental costs, shorter overall duration of treatment, percentage of completed OTMs and the percentage of the treatment of depression and anxiety within GGZ inGeest that is offered in a blended format.

4.7 RSD

The clinic Internetpsykiatrien wishes to continue and further develop the iCBT service and expand the current clinic. Therefore, investments in new software and additional staff will be taken. Multiple implementation goals are indicated by the clinic. It has been decided politically that all five regions of Denmark will be implementing iCBT, and it may be that Internetpsykiatrien will deliver the iCBT treatment on behalf of all regions. This is to be determined ultimo 2017.

The goals include a larger intake of patients, employing more clinicians, to further develop and adapt the workflow of the clinic, to accommodate the new situation and to include comparable amounts of patients from all regions based on background population. Generally, the clinic aims to increase the awareness and acceptability of the service amongst the background

population as well as relevant other health providers such as GP's, acute mental health wards and mental health outpatient clinics. Furthermore, the service should be taken in use by a broad spectrum of the population measured by socio-economic status, geography, and health parameters.

4.8 UMCG

UMCG wishes to implement MYSelf in general practices throughout the Netherlands. In the process, the number of patients involved, the number of sites involved (as UMCG's first aim) and the number of Health Care Professionals involved will hopefully be increased. More concrete, at least 40 GPs working with MYSelf in June 2019 and at least 90 patients working with MYSelf in June 2019 would be considered a successful implementation.

To achieve these goals, UMCG will actively promote MYSelf (through conferences, demonstrations, brochures and social media) by following an extensive PR plan. Since July/August 2017, general practices have been included and professionals have been trained. Starting from February 2018, MYSelf will be implemented within general practices (as part of RCT).

4.9 CMHTir

CMHTir will implement the IFightDepression Tool in collaboration with the Albanian Ministry of Health and three Mental Health Treatment Centers. At the moment, the translation of the iFD tool for adolescents and adults in Albanian is finalized. In a first phase of the implementation process, the iFD Tool will be adapted in Albanian and will then be delivered in a second phase. Intensity and length of the iCBT intervention will be decided at a later stage once the tool is ready for use in Albanian.

The aim would be to increase the number of patients receiving treatment, to increase the number of Healthcare Professionals providing treatment and to train the CMHC's staff to provide CBT for depression.

In order to achieve these goals, awareness will be raised among Health and Mental Health Professionals as well as people suffering from mental health problems and the general population. Also, CMHTir will be working closely with the Ministry of Health authorities and the Community Mental Health Centers. Trainings and continuing educational support will be provided for the Mental Health Professionals.

Measures of success would include whether the treatment gap for people with depression in Albania could be minimized, whether the number of people that have access to treatment for depression could be increased, and whether therapists and the Community Mental Health Centers are using the IFD Tool.

4.10 MHCPriz

CMHPriz will implement the IFightDepression Tool in collaboration with the Albanian Ministry of Health and four Mental Health Treatment Centers. At the moment, the translation of the iFD tool for adolescents and adults in Albanian is finalized. Intensity and length of the iCBT

intervention will be decided at a later stage once the tool is ready for use in Albanian. The aim would be to train the CMHC's staff to provide CBT for depression, to increase the number of Health Care Professionals providing iCBT and to increase the number of patients receiving iCBT.

In order to achieve these goals, awareness will be raised among Health and Mental Health Professionals as well as people suffering from mental health problems and the general population (through campaigns, websites and outreach materials). Also, CMHPriz will be working closely with the health authorities in Kosovo and the Community Mental Health Centers. Trainings and continuing educational support will be provided for the Mental Health Professionals.

Measures of success would include, whether iCBT could be established as a new treatment service within the mental health system in Kosovo, whether the treatment gap for people with depression in Kosovo could be minimized, whether the number of people that have access to treatment for depression could be increased and whether therapists and the Community Mental Health Centers are using the IFD Tool.

4.11 ANU

ANU wishes to compare methods of implementation in order to increase the program's uptake of use by individuals in the communities and patients in primary care. Compared methods will be direct-to-consumer advertising via social media (self-referral) vs. implementation processes via GP clinics and pharmacies. During this process, barriers and facilitators of uptake, effectiveness and adherence will be identified.

The service is not active at present but will be available again in early 2018 and will run as implementation-as-usual for six months. Afterwards, GP clinics will be added to the implementation process (randomized within geographical regions). Data collection will be completed in late 2019 and findings will be disseminated in 2020.

ANU's goals include an increased number of patients and program uptakes and increased numbers of Health Care Professionals involved.

Measures of success would include whether knowledge about optimal settings for implementation of low-intensity iCBT could be generated and whether other groups of researchers planning implementation activities could profit from that knowledge.

4.12 BDI

The Black Dog Institute is internationally recognised as a pioneer in identification, prevention and treatment of mental illness. Regarding the implementation of StepCare, the flow of participants through the stepped care intervention is to be determined and barriers and facilitators of successful flow will be examined.

The effectiveness and cost effectiveness for patients in intervention general practices will be compared relative to 10 control matched general practices, and differences in referral patterns between intervention and control general practices will be determined. Through this evaluation process, BDI seeks to implement the Black Dog Institute Stepped Care service in 15 (50%) of the 31 Primary Health Networks (PHNs) in Australia.

Within these PHNs, the aim will be to increase usage of the service to 80% of GPs in participating practices and to increase uptake of iCBT for anxiety/depression to 5% of adults who visit their GP in a year. Also, the translation of the stepped care service to other patient groups and other clinics, such as for patients with diabetes or eating disorders or child health clinics, will be explored.

In order to achieve these goals, partnerships with PHNs for research and ongoing service delivery will be built and PHNs for the StepCare service will be selected as demonstration sites. An expert advice and support service for stepped care in PHNs will be established and continuing consultation and advocacy with the Australian Government Department of Health will be maintained.

Measures of success would include the number and percentage of PHNs implementing the StepCare service post-evaluation, the number and percentage of GPs using the service on a regular basis and the number and percentage of patients using iCBT as a treatment for anxiety and/or depression as a result of the StepCare service.

4.13 Communalities and differences

Most partners share the common goal of increasing the number of patients enrolled in the service, participating sites and health care professionals involved. Other common goals include the increase adherence to the iCBT program and patient's satisfaction, as well as the provision of a cost-effective treatment in routine care.

Table 12. Broad implementation goals

SITE	INCREASE INCLUSION NUMBERS OF		
	Patients	Sites	Healthcare Professionals
ASLTO3	X	?	X
BSA	X	X	-
DF	X	X	X
FFM	?	?	?
GET.ON	X	-	X
GIG	X	?	X
RSD	X	X	X
UMCG	X	X	X
CMHTIR	X	X	X
MHCPRIZ	X	X	X
ANU	X	-	X
BDI	X	X	X

When asked to further describe their implementation goals, results get heterogeneous as well as vague. 67% of implementation sites (n = 8) specifically express their wish to extend the reach of their treatment. Three implementation sites (25%) set the goal to increase the efficiency of service delivery, reduce the burden on the provider or ensure the cost-effectiveness of the treatment. While three partners (25%) specifically mention the goal to

further improve their iCBT solution, one partner expresses the goal to improve the service according to collected feedback. Two (17%) of the partners each mention the training of providers, the dissemination of knowledge and the gaining of knowledge about the target population. Three (25%) implementation sites each plan on the collection of data in order to support the efficacy and effectiveness of the service and to increase the influence on a political level. Additionally, the certification of the service is named by one partner.

It becomes clear that the overlap of specifically named goals for the implementation process is limited. Furthermore, the degree of consideration of the setup of specific goals appears to be varying between the sites.

Additionally, partners were asked about their implementation plans for the next three years. An emphasis is put to the experiences iCBT brings to the organisation, the necessity of training and the expansion of these competences. Here, partners want to rely on the knowledge gained in previous implementation phases and projects. Most partners (75%, n = 9) mention a promotion, dissemination or marketing plan as the plan chosen to reach their implementation goal. Co-operations and networking are emphasised by three partners (25%). One partner mentions the plan to implement a data dashboard to keep track of the service and one plans to systematically identify facilitators and barriers of implementation.

Again, the implementation plans described do not only vary to a huge degree between the sites, they also appear very broad and lack specificity and details.

Table 13. Implementation goals

	ASLT03	BSA	DF	FFM	Get.On	GiG	RSD	UMCG	CMHTir	MHCPRIZ	ANU	BDI
Increase reach	X		X			X	X	X	X	X		X
Increase efficiency of the service, reduce burden on provider (also cost-effectiveness)	X[3]	X[4]				X[5]						
Improve treatment	X[6]	X					X[7]					
Using feedback to improve the service			X									
Certification of the service					X							

[3] "To reduce the time required to reach frequently in person the mental health service and/or the health professionals"
[4] "Deploy the intervention in routine practice, increasing the quality of care provided for patients while not causing any more burden than needed to clinical staff (mostly to GPs)"
[5] "Deliver cost-effective treatments, therefore we need to know the cost-efficient mix of therapists (in terms of qualification and training), optimal number and blending of treatment sessions as well as a good working system of video conferencing for consultations to other professionals, and to reach our target population in a more efficient way"
[6] "To help individuals to self-manage their symptoms appropriately and to promote recovery with the support from iCBT trained health professionals"
[7] "The Mental Health Services of Southern Denmark will continue the iCBT service. The clinic Internetpsykiatrien wishes to continuously develop the service e.g. by investing in new software and to further develop the clinical workflow"

	ASLT03	BSA	DF	FFM	Get.On	GiG	RSD	UMCG	CMHTir	MHCPRIZ	ANU	BDI
Influence on political level (acceptance, reimbursement)			X		X		X					
Collect data to support efficiency and effectiveness of the service						X	X	X				X
Gain knowledge on the target population						X	X					
Dissemination of knowledge						X	X	X				
Training of providers									X	X		

Table 14. Implementation plans

	ASLT03	BSA	DF	FFM	Get.On	GiG	RSD	UMGC	CMHTir	MHCPRIZ	ANU	BDI
Experience/training of therapists	X					X	X	X	X	X		
Promotion and dissemination campaign, marketing	X		X		X	X		X	X	X	X	
Building on previous knowledge	X	X										
Co-operations and networking			X		X							
Design a data dashboard						X						
Identification of barriers and facilitators											X[8]	

[8] "Identification of barriers and facilitators of uptake, effectiveness and adherence to inform further implementation activities"

5. CONCLUSION

This document on the implementation sites of the ImpleMentAll project aims to give a detailed description on the iCBT solutions being implemented, depict the clinical context the services are implemented into and the status of implementation goals and plans of the participating implementation sites. It becomes clear that there is a high heterogeneity in all three described areas, the clinical treatment, the clinical context and the implementation goals and plans.

The variety in services implemented will allow the project to assess implementation strategies for multiple iCBT services, meaning that the implementation strategies evaluated will not be dependent of the form of treatment. Likewise, the diversity of clinical contexts will allow for testing of the implementation strategies in multiple conditions, therefore enhancing the external validity of the tool.

At the same time, this diversity might limit the comparability of the effects of the tailored implementation strategy and impede data collection and analysis. Here it becomes clear, that the composition of the ImpleMentAll consortium entails certain risks such as lack of information on the resources reserved for the implementation activities, the different conjoining research set-ups at the local sites, which are not further elaborated on in this document, details on safety procedures within the specific services, amongst others. Herewith, patients could potentially be excluded (or falsely included) from the projects thus affecting the measured reach within the ImpleMentAll project.

Additionally, the degree of detail regarding the actual content of the interventions entails the risk of bias within the treatment itself. Here, an additional risk assessment is in place and written down elsewhere, as this analysis is beyond the scope of this document.

Additionally, within this first assessment of the implementation-as-usual it becomes clear that the trial sites all engage in specific implementation enhancing activities while often lacking elaborate implementation strategies. Specific implementation goals often do not exceed the increase in the number of involved patients, health care professionals and organisations. There also seems to be a lack of problem analysis and awareness of barriers and facilitators of successful implementation. Moreover, the implementation plans named by the IMA implementation sites mainly include dissemination and marketing strategies as well as (often undefined) problem analysis effort. We assume that this lack of effective implementation strategy is a) common in the field of iCBT implementation effort and b) inhibiting the actual provision of iCBT in routine care. Therefore, we assume that there is a need for effective implementation strategies and especially *tailored* implementation strategies fitting the clinical context and service implemented.

APPENDICES

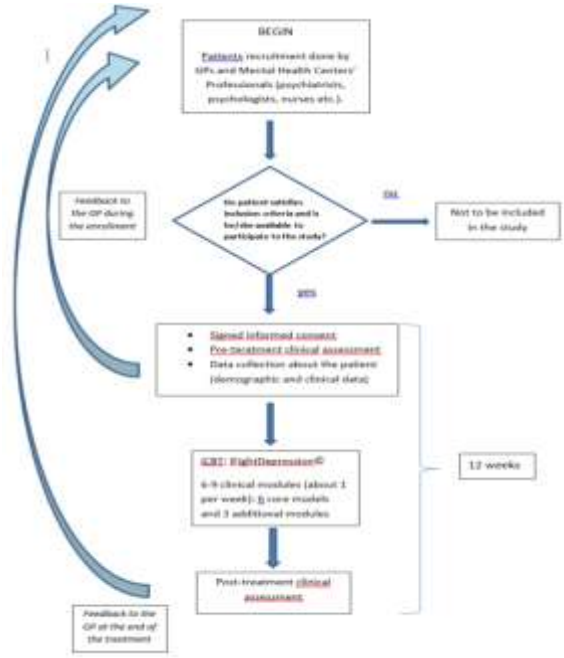
APPENDIX 1: ORGANISATION'S PATIENT FLOW DIAGRAMS

APPENDIX 2: THE IFD TOOL

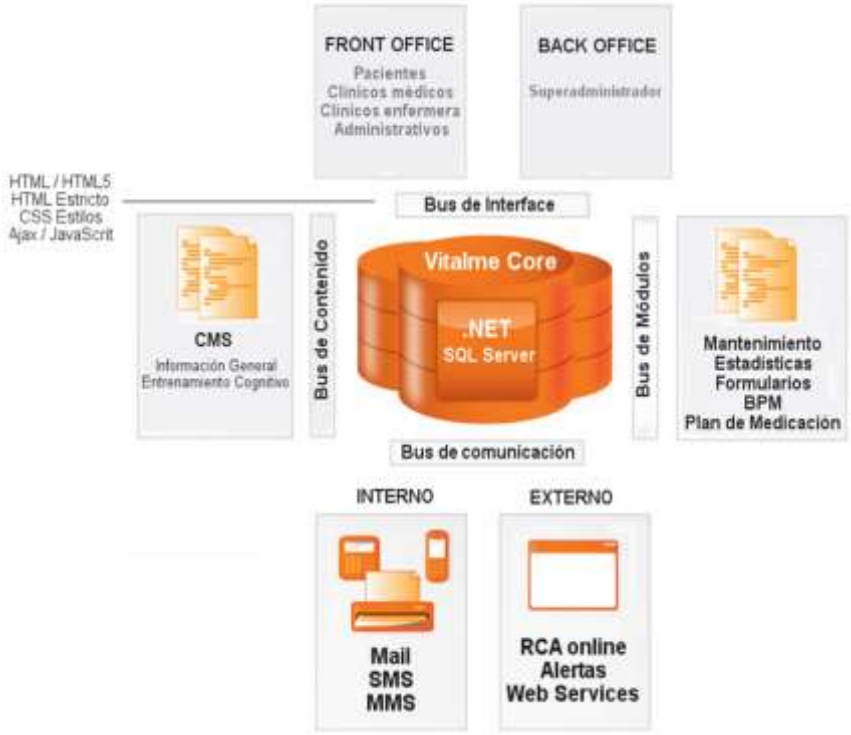
APPENDIX 3: GIG'S BLENDED TREATMENT AND THE MINDDISTRICT PLATFORM

APPENDIX 1: Organisation's patient flow diagrams

A. Patient Flow provided by ASLTO3

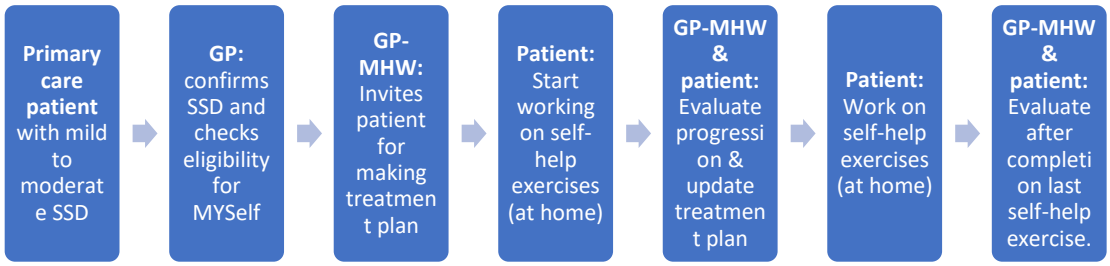


B. Patient flow provided by BSA



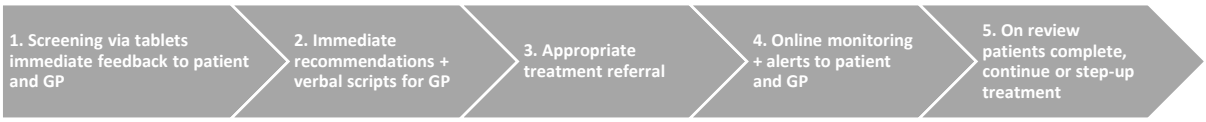
C. Patient flow provided by DF

D. Patient flow provided by UMCG



E. Patient flow provided by CMHTir

F. Patient flow provided by BDI



APPENDIX 2: The iFD Tool

The iFD Tool was developed and is distributed by the European Alliance Against Depression (EAAD).

The tool is based on principles of CBT and consists of six main OTMs and 1-3 additional OTMs. Each OTM contains an educational part and a part where the things learned are transferred into everyday life.

Patients are instructed to work with an activity and mood diary and schedule positive activities as well as breakdowns and "tackle tasks". The OTMs focus on identifying and changing unhelpful thought patterns, adopting healthy sleep patterns, increasing daily activity, monitoring mood and maintaining a healthy lifestyle.

Associated worksheets and exercises encourage users to practice and consolidate new skills and to promote self-monitoring.
The tool is available to the patient up to 10 years after the last login, so the patient can return any time in case of deterioration or a relapse.

For more information visit ww.ifightdepression.com

	Adult Version (25+)	Youth Version (15-24)
Core-Workshops	**1** Thinking, Feeling and Doing **2** Sleep and Depression **3** Planning and Doing Enjoyable Things **4** Getting Things Done **5** Identifying Negative Thoughts **6** Changing Negative Thoughts	
Extra-Workshops	• Healthy Lifestyle	• Healthy Lifestyle • Relationships • Social Anxiety
	Work Sheets and Exercises Mood Rating (PHQ-9)	

APPENDIX 3: GiG's blended treatment and the Minddistrict platform

The blended cCBT programme for depression comprises psycho-education (explanation of the treatment rationale and the general procedures in CBT treatment, 3 sessions), behavioural activation (establishing a balance between compulsory and pleasant activities & building a day structure, 3 sessions), cognitive therapy (examining automatic negative thoughts and dysfunctional assumptions, 2 sessions) and relapse prevention (identifying and adopting techniques/strategies to prevent depressive symptoms to re-occur, 2 sessions).

Patients receive a blended programme of face-to-face sessions and ten OTMs, which will be delivered over a time limited period. Treatment is started and ended with a face-to-face session. The online sessions are delivered through a secure web-based online treatment platform (Minddistrict; www.minddistrict.com). The platform is owned by a commercial stakeholder from which eHealth@Mind, as a clinic within the mother organisation GGZ inGeest, buy the services.

Patients access this platform with a personalized log-in. The website offers information that has been discussed in or adds to the face-to-face sessions. In addition, patients use the website to complete homework exercises, such as monitoring their activities, feelings, thoughts and behaviour. The therapist can follow patients' online progress and provides online feedback weekly.

The face-to-face sessions in the blended cCBT programme is offered by trained mental health workers, mainly psychologists and psychiatric nurses.

The Minddistrict platform does register age and sex of the patients. Also the number of sessions, a mood diary and the time between start and finish of the programme are recorded. Medical information, such as severity of depression symptoms, comorbidity, use of drugs and items on patients' history are not recorded at the Minddistrict platform. This information is recorded in the electronic patient dossier (EPD) in ehealth@Mind.

Patients are referred by their General Practitioner (GP) to treatment in ehealth@Mind. Patients treated in the blended programme have a current diagnosis of minor or major depressive disorder as diagnosed by a psychologist or psychiatrist. Patients need to have sufficient command of the Dutch language, both verbal and written, and have access to the Internet, an e-mail address and a personal computer.

Screenshot of the therapist overview of the OTM: