The government's plan for computerised cognitive behavioural therapy needs proper funding, says Mary O'Hara

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Patricia Hewitt, the health secretary, will tell the annual conference of the mental health charity Mind today about the "next stage" of reform in mental health. She will outline how the government aims to put a greater emphasis on the wellbeing of society as a whole by tackling widespread problems such as mild or moderate anxiety and depression.

The government plans to do this, she will say, by providing an alternative to medication for less serious conditions - namely, computerised cognitive behavioural therapy (CCBT), whereby patients use computer software or web-based therapy packages instead of face-to-face sessions with a therapist.

CCBT, an electronic version of cognitive behavioural therapy (CBT), has a reasonable body of evidence showing its clinical effectiveness, and cost-effectiveness. It seems a sensible addition to the Department of Health's (DH) Improving Access to Psychological Therapies Programme, which includes two pilot "talking therapy" schemes set up last year in response to Lord Layard's call for the availability of such treatments.

CCBT could provide a valuable avenue to treatment for people who are hard to reach, who feel uncomfortable with face-to-face therapy, or who simply can't access it due to inadequate provision in their area. For such people, CCBT could be an indispensable interim treatment that reduces or removes reliance on prescription antidepressants. It can also, as Hewitt will say today, "enable therapy to be provided in a greater number of locations and settings, such as at home or in the library".

In February 2006, the National Institute for Clinical Excellence (Nice) approved two CCBT packages for use in the NHS in England - Beating the Blues, a self-help software package for treating anxiety and depression, and FearFighter, a web-based package aimed at people with panic and anxiety disorders or phobias. PCTs in England are expected to offer both by March 31.

In theory, there appears to be little to argue with. But, in practice, there are fundamental issues that Hewitt needs to bear in mind.

The first is funding. Not a penny of extra cash has been set aside for PCTs to implement or run CCBT. They will be expected to administer it within existing resources, and even if they embrace CCBT, something will have to give to make way for it - at least in the short term, while the predicted savings from fewer antidepressant prescriptions and consultations take time to kick in.

Second, there are concerns about implementation and monitoring. Among these are that overstretched or under-qualified staff could prescribe CCBT but fail to appropriately monitor or assess the patient. Some training will be given, but no formal experience of, or expertise in, psychological therapies is required. In addition, if there are instances where adequate resources, funding, support or monitoring are lacking, the drop-out rate from CCBT could be very high.

It is right for the DH to get behind CCBT. It can work for some people and act as a stepping stone to better mental health. It might well even save the NHS money in the long term. But it needs to be properly resourced, managed and monitored.

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