Centre for Social Work and Social Policy

Mental Health Treatment Online

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November 2007

A report commissioned by the Digital Inclusion Team, City of London

Acknowledgements

The author would like to thank the following for their assistance in providing information, support, contacts and helpful ideas:

Kate Anthony

Emma Brown and all the bloggers who allowed their material to be used at 'mindbloggling'

Jill Collins – Cambridge University Counselling Service

Terry Hanley – 'Kooth'

Ewen McKinnon – Digital Inclusion Team

Professor Jonathan Parker – Bournemouth University

Liz Spreadbury

Paul Waller – Digital Inclusion Team

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The Digital Inclusion Team works on the use of technology either directly or indirectly to improve the lives and life chances of disadvantaged people in England and the places in which they live.

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Foreword

This report is the outcome of work undertaken by Dr. Moira Walker of Bournemouth University, commissioned by the City of London Digital Inclusion Team, to consider the extent, purpose and efficacy of technology in the provision of mental health services in the UK. However, in order to contextualise UK developments, work being undertaken in other countries is considered, both historically and currently.

As this work took place in the short time span of May to October 2007, it was agreed that research would be secondary rather than primary, in that existing published work would be overviewed, and practitioners already working in the sector would be approached. In the event other practitioners also provided input on their views and attitudes towards online services through informal networking. Although it was recognised that ascertaining service user opinion is of the highest priority it was also acknowledged that this could not be done in the time available, although every effort would be made to access their views from existing sources. However it remains a priority to carry out further extensive research with service users.

This work has been carried out at a very pertinent point in the development of online service provision. It is widely recognised that poor mental health is a major problem both nationally and internationally; has profound and wide ranging effects on those who suffer, and that many have no access to services (World Health Organisation, 2006). In 2006 in the UK the Layard Report intensified the debate around the use of technology in service provision by planning the introduction of computerised cognitive behaviour packages in an attempt to make treatment for depression and anxiety more widespread and easily accessible. In October 2007 the government announced plans to further increase the availability of psychological therapies, notably Cognitive Behavioural Therapy, and to make available substantial funding.

At the same time technological advances speed ahead, providing the possibility of more services being provided by non-traditional, non-face-to-face means. These technological advances are paralleled by the increasingly large number of people who now have access to computers; who use them regularly and are

increasingly comfortable with their use. The digital divide does however still exist, with some division between both the rich and the poor, and between the young and the elderly. So whilst technology provides the possibility of increased access and lessening divides it does also carry the possibility of the opposite. In the light of all these developments it is crucial that the contribution of technology; its possibilities and its limitations; its ability to facilitate access to services and the danger of it increasing alienation from such services, are rigorously explored.

This report provides a snapshot rather than a definitive document. It is recognised and acknowledged that this is a rapidly developing, complex, ever fluid and ever changing area of study, and hence completeness is not possible.

This report is commissioned by the Digital Inclusion Team at the City of London and first presented in November 2007 at the UK Universities Psychotherapy and Counselling Association Annual Conference at Bournemouth University.

Foreword References

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Executive Summary

The mental health of the nation is of serious concern, and is also a worldwide issue. Treatment of emotional distress is now a long way from the incarceration of 'lunatics' defined by the Lunacy Acts of the 19th Century, and the physical treatments of the mid 20th Century — lobotomies, electro convulsive therapy (ECT) and insulin coma treatments. The advent of modern drug treatments, and outpatient care in the community; the impact of the 'talking treatments' of counselling and psychotherapy, and the challenge of both the anti-psychiatry movement (Cooper, 1967), and feminism (Showalter, 1987) have radically altered both perceptions and approaches to those with mental health difficulties.

In addition to the influence of these changing attitudes, the rapid advances in technology in 20th Century Britain has also impacted on both how mental health services are delivered, and the types of help available. The roots of this technological influence can be traced back to the 1950s (Perednia and Allen, 1995) although the use of technology has greatly accelerated during the past two decades. The purpose of this report is to describe the use, extent, purpose and efficacy of technology in the provision of mental health services, drawing on work both within the UK and globally. It should be noted that this picture is never static and what is provided is a snapshot of part of an ever changing, rapidly moving world.

Service range

Services range from those using the telephone, which generally pre-date those using computers and the internet, to an enormous variety of other technologically based interventions. The voluntary sector has, and still does, make extensive use of telephone help lines, whilst other practitioners use the telephone as an adjunct to, or in place of face-to-face work. Telepsychiatry was a relatively early development that has become more sophisticated. The use of computerised packages for cognitive behaviour therapy (for example 'Beating the Blues' and 'Fear Fighter') is of recent origin with plans for this to become accessible to large numbers (Layard, 2006). Chat rooms, online support groups, and online counselling and psychotherapy are becoming increasingly evident.

Specific groups are being targeted as suitable for online interventions — young people; rural population, and those with addictions are examples.

Efficacy

Existing research, service user opinion and project evaluations all suggest that online approaches have much to offer some, will not suit all and need further careful study. Griffiths and Cooper (2003) point out pragmatically but usefully that although evidence is not conclusive regarding the effectiveness of internet approaches, there is no evidence either to the contrary, and this is in the context of the evidence base for most therapies being less than complete. Rochlen *et al.* (2004) conclude that 'The findings of studies evaluating the outcomes of online counseling have been mostly positive, reporting significant client improvement on a variety of outcome measures. These results provide preliminary evidence that online models of counselling can be effective in reducing clients presenting problems and symptoms. Research has also offered preliminary support to the notion that online counseling may be useful for populations that underutilize clinical services, such as disabled or rural individuals' (847).

The ongoing CORE Survey of psychological therapy, run by the Institute of Psychological Sciences at the University of Leeds, has found that it is the patient's relationship with their therapist that is key, rather than a specific approach (accessed 29.10.07 from http://www.psyc.leeds.ac.uk/ptrc/research.htm). In an article in *The Times*, Phillip Hodson, a fellow of the British Association for Counselling and Psychotherapy, says, 'This is not what patients say they want. Most surveys show they wish to talk to a live human being' (accessed 29.10.07 from http://www.timesonline.co.uk/tol/life_and_style/health/article1581821.ece).

Concerns

Some practitioners express concern that online services provided by the NHS may be viewed as a cheap and a short term option that may not be accurately responding to service users needs and that staffing levels will be placed at risk in order to achieve what may appear cost effective, but may not be if scrutinized. It is crucial that practitioners are heard and these concerns are not dismissed as simply resistance to change. This may be one aspect but mental health practitioners hold vital knowledge and information about what works, and

crucially what service users want. Similarly, it is vital that service users' views are heard and taken seriously. For instance, a major cause of mental ill health in the UK is the ongoing impact of childhood abuse (Newmann, 1998; Walker, 2003). Bagley and McDonald (1984) argue that sexual abuse before the age of 14 is the major predictor of long term mental health problems. There is widespread evidence that this group needs and wants long term help, and not short term interventions, by whatever means these are delivered. In a report on the experience of abuse survivors receiving services in Yorkshire, Hooper *et al.* (1999) state that

'More resources for free long term psychotherapy and counselling are needed... resources to provide these services appear to be unevenly distributed geographically. Both the extent of provision and equity between areas needs to be addressed. It needs to be taken into account that to be beneficial, therapeutic relationships may need to last several years' (1999:49).

Clearly it would be inequitable if the only people to effectively access what they need are those able to pay private practitioners: equity and accessibility are key. Online approaches offer creative and exciting possibilities but they are not a panacea.

Creating a relationship without face-to-face communication

An important question relates to whether it is possible to meaningfully connect with a client through distant communication technologies. It is accepted that a therapeutic alliance is crucial to any approach working well, and it is noteworthy in his discussion of 'Beating the Blues' (Leonard, 2004) that this worked best where support from a person was offered and in place. Studies have attempted to explore the question of working alliance (Hufford *et al.*, 1999; Cohen and Kerr, 1998; Cook and Doyle, 2002) but to date results are mixed and further enquiry needed.

The digital divide

The question of the digital divide needs serious consideration. Clearly many would be excluded from online services by lack of access to a computer and internet, although this does not apply to programs on offer within services (for example, 'Beating the Blues'). However there is a danger that online provision

could end up unavailable to populations already under-served by traditional mental health interventions. So it is crucial that the digital divide does not both mirror and further reinforce existing divides.

Ethical issues

Careful thought has to be given to ethical issues and ethical practice particularly in relation to risk management and confidentiality. It is also important that any practitioner offering online services has both the specialist clinical training and the required technological expertise. They also need to ensure that recipients of any service have the necessary technology and knowledge to effectively access help. Many will be in their own homes, using a home computer without access to technical support. If suddenly cut off with no means of reconnection this could exacerbate feelings of isolation and alienation rather than alleviate them. Some practitioners express concerns about the reliability of technology and describe instances of technology failing and vulnerable clients left feeling abandoned with no-one to turn to. It is not possible to ascertain how widespread these occurrences are but they too need to be addressed. To operate successfully, technologically-based interventions have to be very well resourced in terms of skill levels, training, equipment and technical and personal support.

It is also important for practitioners to know when to stop online work and move into other approaches and to have the necessary knowledge base to do so. There is also a wider ethical issue relating to the quality of the plethora of information and services available on the net. A huge amount is obtainable and it is a real challenge to all to ensure that only the best quality is available to patients and carers.

Possibilities

The use of information and communication technology carries potential and possibilities, especially when used to offer new or extended forms of therapeutic service, including when offered in conjunction with other approaches. In the same way that modalities using the telephone have never replaced face-to-face work but are an invaluable addition to them, so it is likely that ICT (Information and Communication Technology) will become incorporated. It is crucial to remember that whatever and however services are offered the human

relationship remains at the heart of the matter. Connection and care are paramount although contexts and methods develop and change. As Chester and Glass (2006) say 'this study was a living example of the way people use social mechanisms to adjust to a given communication medium and of the way new procedures for managing human relationships can emerge in response to new technologies. It reinforced the idea that the success of computer mediated communication may depend more on human factors than on technological factors' (281).

A profile of mental health in the United Kingdom

One in four people are affected by a mental health problem at some point in their life with many receiving little or no help. Powell *et al.* (2003) in a survey of users of internet depression communities showed high levels of untreated and undiagnosed depression, and the National Institute for Clinical Excellence (NICE, 2004) indicated that about half of depressed people do not seek help. Depression is not just a UK problem: the World Health Organization estimates it to be a global health problem affecting approximately 121 million people worldwide (WHO, 2006) and according to this report fewer than 25% have access to effective treatment. Managing mental health in the community is therefore complex, serious and of grave concern: the WHO predicts that by 2020 mental health disorders will be the second most common cause of death.

More women than men become depressed, with one in four women needing treatment for depression at some time in their lifetime, compared to one in ten men. The reasons for this are unclear, but possibly due to both social and biological factors. However it has also been suggested that this apparent gender difference is inaccurate and depression in men may have been under diagnosed because they present to their GP with different symptoms (accessed 28.08.07 from The Mental Health Foundation http://www.mentalhealth.org.uk/information/mental-health-overview/statistics/). This may go some way to explain that 75% of all suicides are by men, which remains the most common cause of death in men under the age of 35 (2005, Department of Health). Additionally, men are more likely to have alcohol or drug problems, with 67% of those drinking at 'hazardous' levels being male, with 80% of these being alcohol dependent (The Office for National Statistics, 2001).

Depression does not go away with age, with one in five older people living in the community and two in five living in care homes affected. Dementia affects 5% of people over the age of 65 and 20% of those over 80, and about 1.2% of people in the UK have dementia at any one time (Jacoby and Oppenheimer, 2002). This picture of mental distress is not limited to the adult population. Amongst 16–19 year olds about 6% of boys and 16% of girls have a mental health problem (Department of Heath, 1999a). A more recent report from the Office for National

Statistics (2005) paints a similar picture suggesting that overall one in ten children between the ages of one and 15 has a mental health problem.

Pockets exist in the population where the problem is particularly severe: more than 70% of the prison population have two or more mental health disorders; male prisoners are 14 times more likely to have two or more disorders than the non prisoner male population, and female prisoners 35 times more likely than other women (Department of Health, 1998). The suicide rate in prisons is almost 15 times higher than in the general population with the rate in 2002 being 143 per 100,000 compared to nine per 100,000 in the general population (Samaritans, 2004).

The unemployed are also vulnerable: it has been estimated that one in four unemployed people have a mental health problem (The Office for National Statistics, 2001). Mental health problems are also thought to be higher in minority ethnic groups than in the white population, but they are less likely to have their mental health problems detected by a GP (NIMHE, 2003). About half of people with common mental health problems are no longer affected after 18 months, but poorer people, the long-term sick and unemployed people are more likely to be affected for longer than the general population (Office for National Statistics, 2003).

The financial implications of mental ill health are significant. The Layard report (2006) described how there are more mentally ill people on incapacity benefits than the total number of unemployed people on benefit. In 2000 the most common diagnoses were mixed anxiety and depression (7% for men, 11% for women); anxiety (4% for men, 5% for women) and depression (2% for men, 3% for women); (accessed 07.09.07 from http://www.statistics.gov.uk).

Governmental concern over the extent of poor mental health is reflected in recent initiatives. The National Service Framework for Mental Health (Department of Health, 1999b) has identified improved access to psychological treatment as a key objective whilst the Mental Health Policy Implementation Guide (Department of Health, 2001) acknowledges that few Primary Care Trusts actually provide a full range of relevant mental health services. Therefore

traditional mental health care serves only a fraction of the population who need it, suggesting that alternatives need urgent and serious consideration.

In 2007, the Department of Health launched the Improving Access to Psychological Therapies programme (IAPT). The Government set up two pilot sites in Doncaster and Newham to test different models for the delivery of psychological therapies. In October 2007 the government announced that £170m would be made available by 2010 to increase the availability of psychological therapies, notably Cognitive Behavioural Therapy. Building on these two pilots 20 new areas will be targeted for similar programmes to be developed in 2008, prior to services being extended to all parts of the country in the next decade (accessed 21.10.07 from http://www.gnn.gov.uk/environment).

The digital scenario

A report by the Office for National Statistics, 'Focus on the Digital Age' (HMSO, 2007), shows that in terms of households being able to receive broadband services the digital divide in the UK is diminishing. In 2007 this figure is now 74% against 40% at the end of 2005. 2003 was significant as in that year more households had internet connection than did not. The report also depicts Britain as increasingly adopting internet technologies — both for business and leisure. However paradoxically and simultaneously a growing digital divide is described with a noticeably and significantly different picture existing for the poorest in society with others having considerable financial and technological advantage. 90% of the richest 10% of households have internet access, a home computer and mobile phones and 80% have a digital television service. In the poorest 10%, only a fifth has internet access, 30% have a computer, 40% have a digital television service and just over half has a mobile phone. So whilst the lives of many have undergone major changes due to mobile phones, access to the internet and digital televisions, others remain excluded with 8% of households having access to none of these. Low income households were more likely to own a mobile phone or have digital television rather than internet access or a computer.

As well as indicating a clear differential between rich and poor the report also described an age-related gap, with older people having less access to new technology and the internet. The study showed that 55% of over 50s had not used a computer in the past three months, compared with 13% of people aged 16 to 30. A lack of interest or knowledge was cited as the most significant factor in the older age group although there was some gender difference — women over 65 were technologically more competent than men, and more used to the internet. As noted above the elderly are a vulnerable group in respect of mental health so any discussion of online mental health services needs to take serious note of this age differential. The picture appears starkly different in relation to a younger age group with the 'UK Children Go Online' project estimating that 75% of young people have access to the internet at home and 92% have access at school (Livingstone and Bober, 2004). Regional variations were also significant according to the 2007 report: London has the highest average weekly income in

the country with the largest percentage of homes with internet access, whilst the north-east, with an average weekly income approximately 40% lower has 56% of homes unable to access internet, 14% less than the capital. However the reality remains that for many ‘the internet is no longer perceived as a different and separate world, but rather as a transactional space embedded in everyday life’ (Wellman and Haythornwaite, 2002:156).

Mental health and the digital world: an introduction

In parallel with the increasing highlighting of mental health need the internet has been identified as potentially being an important source of services with its capacity to reach people without access to traditionally delivered mental health services (King, Spooner and Reid, 2003). A Harris Poll (2001) found that almost 100 million Americans looked for health information online. Mental health is no exception — many turn to the internet for support and information on a variety of related issues and it proliferates with websites offering help and advice.

Eysenbach (2001) suggests that 'e.health characterizes not only a technical development, but also a state-of-mind, a way of thinking, an attitude and a commitment for networked, global thinking, to improve health care locally, regionally, and worldwide by using information and communication technology' (2001:20). Interest in, and recognition of, the role of technology in supporting those suffering mental health problems and their carers has a history dating back some years. Many of the early developments took place in the US but of course for those accessing help over the internet distance is not necessarily an issue, the world becomes a smaller place and geography no barrier. In the mid 1950s, psychotherapy via video was first attempted for educational purposes in the Nebraska Psychiatric Institute in the USA when a video link was established at one of its satellite hospitals (Wittson *et al.*, 1961). A closed-circuit television system was used for live transmission of therapy sessions to students. Following on from this they developed other services enabling the university's psychiatry department to link and work with a state mental institution about 100 miles away.

Telepsychiatry (a term used to describe the application of telemedicine and telecare to mental health, thereby enabling psychiatry to be offered at a distance using technology to link patients with psychiatrists) also first had its roots in the 1950s in the US (Perednia and Allen, 1995). It continues today to be a method for giving access to patients who would otherwise be geographically excluded (Fortney *et al.*, 1999). Counselling services also experimented with computer programs and in the 1970s 'Eliza' provided a type of non directive counselling

(Weizenbaum, 1976). From the 1980s a wide range of types of assistance began to flourish and forms of online counselling and psychological help ranged from short term crisis intervention and computer assisted brief therapy (Peck, 1994), to long term therapy for example, CyberAnalsis (http://psychologytoday.com/articles/pto-19990301-000005.html) (Nakazawa, 1999). The earliest known organised service to provide mental health advice on line was "Ask Uncle Ezra", launched in 1986 to provide a free service to students of Cornell University, named after Ezra Cornell, the University's founder. Ainsworth (2002: 195) describes how from 1983 she set up and participated in a variety of online support groups.

The lack of services due to distance and inaccessibility, particularly in respect of rural populations was the driving force in many early initiatives in both mental health and in health. In the 1980s, the Norwegian government introduced a National Telemedicine Programme offering those living in small rural communities an alternative method of accessing services because specialist care was not always available locally. A telemedicine centre was started in the north of Norway at the University of Tromso, leading to the creation and development of other specialty telemedicine projects (Gammon *et al.*, 1996). Similar networks developed in Western and South Australia in the early 1990s for similar reasons of distance and the desire to make services more accessible.

In the 1990s online advice became more widespread and websites such as 'Depression Central' (http://www.psycom.net/depression.central.html) were set up. Others offered free mental health within a chat room, 'psychcentral', established in 1995 being one (http://psychcentral.com/chats.htm). Fee based services also began to emerge online in the 1990s, for example 'Shareware Psychological Consultation'. The responses these and other similar services received indicated that a considerable number of people were ready to access and receive help via the internet. 'Help Net' and 'Shrink Link' were two other fee-based mental health advice websites available in the 1990s although neither exist today.

'Cyberpsych' chat service (http://www.homeroaster.com/procedur.html) began in August 1995, focusing exclusively on e-therapy interaction via real-time chat. Another early example of the use of ongoing e-therapy included the 'Pink Practice' in London (http://www.pinkpractice.co.uk). Also in the UK Samaritans have been leaders

in the field of internet helping relationships. Samaritans is staffed by trained volunteer crisis counsellors providing telephone and email responses to suicidal people 24 hours a day anonymously and without charge (http://www.samaritans.org.uk).

The founding of the International Society for Mental Health Online (or ISMHO, http://www.ismho.org) was a key landmark in the development of e-therapy. This is a non-profit-making organisation founded in 1997 which aims to promote the understanding, use and development of online communication, information and technology for the international mental health community. It provides support for therapists operating online and is an invaluable resource providing information, opportunities for discussion for those wishing to provide mental health services online. A central aspect of its activities is sponsoring a clinical case study group providing a forum for the consideration and study of clinical issues and interventions.

Recently in the UK interest has grown in the possibilities of online responses to mental health and the development of computerised treatment. The National Institute for Health and Clinical Excellence (NICE) 2006 guidelines indicate that computerised CBT packages may be of value in managing anxiety and depression. Researchers at City University, London, found that computer-aided therapy offered at mental health treatment centres can cut NHS waiting times. Working with an NHS centre over a period of five years they concluded that after completing eight sessions of 'Beating the Blues' 64% of service users were successfully discharged (accessed 22.10.07 from http://www.city.ac.uk/news/archive/2007/09_september/18012007_1.html). The Layard Report (2006) also gives credence to such interventions. This report stressed the need for psychological therapy being available to all those with depression, chronic anxiety and schizophrenia. Although NICE guidelines have previously stated just that, Layard noted that the reality differed from the ambition. Therapy services are insufficient and in most areas, waiting lists are over nine months, if available at all. The Layard Report stated that by 2013 adequate psychological services should be in place throughout the country arguing that the cost would be met by the reductions in incapacity benefit as proper services would enable people to return to paid employment. This would require 10,000 therapists and 250 local services, with 40 new services opened each year till

2013. Two trial programmes based on the Layard proposals are currently underway in Doncaster and Newham.

Following Layard, the 'Improving access to psychological therapies (IAPT) programme: Computerised cognitive behavioural therapy (cCBT)' came into force in April 2007 (Department of Health, 2007). This aims to have computer-based therapy for mild depression and anxiety available to all patients in England. Two computer programs 'Fear Fighter' and 'Beating the Blues' will be provided. Both programs teach patients how to deal with stressful situations and negative thoughts. 'Beating the Blues' treats people with mild to moderate depression and 'Fear Fighter' is aimed at people who have phobias or suffer from panic attacks. The role, possibilities and limitations of these programs will be explored in more detail later.

In 2007 The National Endowment for Science, Technology and the Arts (NESTA) (http://www.nesta.org.uk) launched an initiative in partnership with the Mental Health Foundation (MHF) (http://www.mentalhealth.org.uk) and other relevant groups to develop mental health projects. These may be based on new and improved processes and services, but could also involve the use of technology.

Currently the range of technology-based mental health interventions is vast, enabling practitioners and clients to communicate using telephone or computer to facilitate contact when circumstances or choice make this approach preferable, necessary or convenient. Telepsychiatry has been mentioned but others include various telephone services offering counselling, crisis intervention, helplines and information lines. These have been in evidence for many years on a one-to-one basis or incorporating conferencing features to work with a group. Other resources are support groups online either facilitated or non-facilitated; blogging; online communities (for example, 'DepressionNet' http://www.depressionet.com.au); private one-to-one chat; chat rooms where individuals talk with other like-minded individuals; and asynchronous or synchronous email counselling or psychotherapy, including where this is used as an adjunct rather than an alternative to face-to-face work. Online, email and SMS-based remote cognitive behaviour therapy are offered by organisations such as Addictions UK and computerised CBT self help programmes are gaining in popularity and credence.

Non- traditional mental health: examples of services and provision

The efficacy of provision, what works and for whom, will be reviewed later in this report. The following describes examples of the range offered beyond traditional face-to-face services.

Telephone provision

The telephone as a way of providing either counselling or other services is well established and very familiar nowadays. In 2000, 98% of those surveyed in an American Psychological Association study reported providing services by telephone (Hines, 1994; Sanders and Rosenfield, 1998). Some practitioners use the telephone to offer a service in its own right, whereas others use it as an addition to face-to-face work rather than as an alternative. Lovell *et al.* (2000) describe how in treating obsessive compulsive disorder telephone interventions used in addition to other approaches improved outcomes. The telephone is also used to follow up patients and Simon *et al.* (2000) report on a trial with general practitioners giving telephone feedback regarding medication with depressed patients. They compared a system of giving feedback alone with giving feedback, including systematic follow-up by telephone. The latter significantly improved clinical outcomes in this sample.

Examples of structured telephone counselling programmes, in which this is the sole method of communication, also exist. Hugo *et al.* (2000) describe a telephone based mental health service for women with eating disorders. They suggest that structured telephone counselling for bulimia can be a feasible and successful alternative to conventional treatment. In another study cancer patients were given long term psychotherapy over the telephone (Donnelly *et al.*, 2000). They found the experience helpful, and when asked to rate the service were all positive, giving ratings of excellent or good.

Teleconferencing, whereby a group is linked by telephone for group counselling has also been established, for example to help cancer patients with the psychological impact and effect of their illness (Rosenfield and Smillie, 1998). A strong bond was established, support given and received, and the process of group development and group dynamics similar to that identified in face-to-face groups. The authors conclude that telephone group counselling can be an

effective and acceptable of bringing together isolated individuals for short term work. Shepard (1987) considers a further aspect, that is how the telephone assists individuals seeking and needing help, but unwilling or unable to attend face-to-face sessions. Telephone helplines have been in use for many years in the mental health field and are extremely well used by those only able to disclose what is often distressing detail knowing they will never meet the person they disclose to. The Telephone Helplines Association (http://www.helplines.org.uk/MH_Partnership.html) runs the Mental Health Helplines Partnership Project which contains a core group of representatives from 24 helplines from across England.

The number and range of helplines is vast, offering advice on issues ranging from depression to eating disorders to abuse. They are too numerous to list and discuss individually but in the UK the Samaritans and Saneline are particularly well known. Samaritans offers various forms of support and its email service will be discussed later. However it is perhaps still best known for its telephone service, the first to be set up in 1953. It remains the only emotional support service whereby a trained Samaritan is contactable and available in person 24 hours a day to everyone, everywhere in the UK and Republic of Ireland. A single number can be called from anywhere in the UK and charged at the price of a local call. It is a truly impressive service in terms of accessibility, extent and low cost.

SANEline (http://www.sane.org.uk) began in 1992 as the first national out-of-hours telephone helpline offering practical information, crisis care and emotional support to anybody affected by mental health problems. The service is open every day and receives tens of thousands of calls every year from service users, family members, carers and health professionals. SANEline is a founder member of the Telephone Helpline Association which sets service standards and provides guidelines for handling calls and evaluating and reviewing. SANEline operates Language Line offering interpretation in over 100 languages and also uses Type Talk for those with a hearing impairment.

It would be difficult to discuss telephone support without reference to ChildLine. Whilst this report is primarily concerned with the young adult and adult population the work of ChildLine offers an impressive model. ChildLine is the

UK's free, 24-hour helpline for children in distress or danger staffed by trained volunteer counsellors backed up by trained supervisors and others professionals. It was launched in 1986 and has answered 22 million calls between its inception and March 2006. In 2002 it launched a redesigned interactive website providing information and advice using software which enables children to search for information in their own words. It allows for spelling mistakes and colloquialisms and users are able to ask a question in their own words. This technology could usefully be applied to websites for adults who may have difficulties with language and communication.

The telephone has not replaced face-to-face work but it clearly has a very significant role to play, both in services solely based upon telephone use, and for the many that use a combination of telephone and other modalities. This may prove a useful model for increasingly using information and communication technology, as a means of providing greater choice to greater numbers who may otherwise be excluded for a variety of reasons from more traditional approaches.

Telepsychiatry

Telepsychiatry and telemedicine came into being as a means of improving communication between primary and secondary care. Harrison *et al.* (1996) describe how this enables a GP to join a consultation with an expert elsewhere. This method has been extended to the psychiatric setting and the term 'telepsychiatry' was first referred to by Dwyer in (1973). Telepsychiatry has been defined as 'an evolving concept based on models of telemedicine. It is conceptualized as a practice of health care delivery that can include diagnosis, consultation, treatment, and transfer or exchange of medical and other data and educational materials through interactive audio, visual, and data communication' (Miller, Burton *et al.*, 2005:539).

Kavanagh and Yellowlees (1995) writing in the US context suggested that this approach may be less threatening than face-to-face psychiatric interventions as the patient has more control: for instance they can decide more easily to leave a consultation, with less anxiety about upsetting the other person. Chae *et al.* (2000) in South Korea compared face-to-face and distant psychiatric assessments. A multiple regression analysis showed that telepsychiatry was more acceptable to patients with less severe mental health problems. Zarate *et*

al. (1997) compared the reliability and acceptability of assessments by videoconferencing but concluded that their results were insufficient to confirm if this method is a reliable way to practice psychiatry.

Another study (McLaren *et al.*, 1999) describes how telepsychiatry has been utilised to involve GPs in discharge planning meetings for patients on an acute adult psychiatric ward. This innovation was found helpful by both patients and by professional staff, enabling a level of direct communication at a key moment in treatment that would otherwise have been impossible. A pilot telepsychiatry service (May *et al.*, 2000) was established for patients in the north-west of England who had anxiety or depression. This study recommended that more robust evaluation was needed before these types of interventions were used more widely. McLaren (2003) further describes a number of pilot studies demonstrating the range of clinical tasks that can be carried out remotely using interactive television. These include psychiatric consultation with out-patients; joint assessments with primary care teams; psychiatric assessments with the patient and the GP both present; psychiatric assessments in prison; linking acute psychiatric wards with psychiatric intensive care units and maintaining therapeutic relationships with the staff. However he argues that: 'In spite of pilot projects and prophets foretelling dramatic benefits from technology for more than 40 years, telepsychiatry has made little impact on mental health care outside of some parts of rural Australia and the USA' (59).

Psychotherapists and counsellors online: fee paying services

Online counselling has more recently found a place in mental health service provision. Ainsworth (2001) notes that this has been taken up largely by private practitioners and more slowly by traditional mental health service providers. Statistics tend to show more women than men using internet counselling services although early users of the internet in the UK and the USA tended to be young, male and well off (Castells, 2000). The potential advantages of online counselling echo those claimed for telephone counselling (Rosenfield, 2000). Currently, the most common mode of delivery for internet psychotherapy is asynchronous text-based email (Grohol, 1998).

Online therapists are using, exploring and considering a wide variety of modes of internet communication in working with clients. Some of these are email

(sometimes encrypted[1], sometimes not), real-time chat, secure web-based messaging, videoconferencing, and voice-over-IP (internet phone). Many therapists working online use more than one method and therefore clients have a choice in terms of preference albeit governed by the technology available to them. However as broadband internet connections become more available so the range of types of service available grows. Email and chat are characterised by having no visual or voice connection, and this aspect and its ramifications will be considered more fully later.

Other psychotherapists and counsellors may prefer face-to-face work but nevertheless use telephone and email as a useful extra tool. It enables communication between sessions when appropriate, can help maintain the therapeutic relationship if a client moves or travels frequently for their jobs, or in other circumstances which make regular face-to-face work difficult. Kaplan (1997) describes using a videophone for the psychoanalysis of two patients who moved during therapy. It could be argued that psychoanalysis using technology might facilitate aspects of psychoanalytic work by increasing fantasy and aiding exploration of the perceived relationship.

Technology based modalities might be expected to impede process by lacking the nonverbal cues, but it may not necessarily impair interaction quality (Grohol, 1999). There are moreover some indications that clients and therapists may experience text therapy as similar to traditional therapy: Fenichel *et al.* (2002) note 'the similarity between a text-based transcript and a comparable office session' and comment on 'the expressiveness and depth of the text-based communication' (26).

Currently internet psychotherapy mainly uses asynchronous text-based email (Grohol, 1998) whereby a client is in email communication with a therapist and awaits their reply. Generally, the contract would indicate the time span in which the client can expect a reply, may specify the maximum length of the reply and as with other counselling there may be a contract for a given and agreed

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[1] Encryption is a way of achieving data security. To read encrypted text you need access to a password to decrypt it. Unencrypted data is referred to as plain text , encrypted as cipher text.

number of sessions/responses. Synchronous real time 'chat', email, discussion boards and interactive self-help are also in evidence (King *et al.,* 2003).

Relate, a service traditionally offering help to couples but nowadays offering an extensive range of counselling services, has developed email counselling and is charged at a similar rate to face-to-face services. Clients are asked to complete an online form about their relationship query, pay the required amount (£28.50 in August 2007) and a Relate counsellor will email a response, usually within four working days. A follow-up consultation with the same counsellor or a phone counselling session can be offered thereafter.

Email mental health support services: non fee paying

Email services can be offered by an individual or by an organisation. Samaritans, perhaps best known for its telephone work first began email support in 1992 when a volunteer in the Cheltenham branch started a small pilot scheme for those in distress who could email Samaritans at jo@samaritans.org. The name ‘jo’ was selected because it was not gender specific and was short and easy to remember. It marked an important new initiative in trying to reach those in need who would not contact by other means. The scheme was piloted and gradually grew until Samaritans formally launched the service in December 2002, (Spinney, 1995). 118 branches have gone online, receiving an average of 300 emails a day, routed via a central server which removes the sender’s details thus maintaining anonymity. Emails are answered within about nine hours. Samaritans are exploring other ways of using new technology to provide services, particularly for young people.

Similarly, SANELINE, has developed an email service, SANEmail, focused primarily at reaching young people with mental health problems who may be more comfortable using email rather than the helpline. It also aims to help those with either physical disability or mental illness that prevents them using the helpline. SANEmail aims to explore the options available to people and help them to make informed choices by providing emotional support, information on services and treatments, mental health legislation and the mental health system.

Kooth is an online counselling service for young people provided by Stockport council and an online counselling firm, and is believed to be the first free service

of its kind provided by a local authority: 'The council's decision to launch the online counselling service was influenced by a Samaritans survey, which found that a third of young men would rather use email to talk about their problems' (accessed 24.08.07 from Website https://www.kooth.com). It therefore wanted to encourage more young men to seek help. The site was launched in March 2004 and has won several awards and has attracted many registered users in the Stockport area. In addition to offering online support it aims to make it easier for young people who want face-to-face counselling to get access to the council's outreach team.

Other resources for young people are 'Talk to Frank' a technology based service which is fully computerised giving drugs advice. Those contacting 'Frank' can email, telephone or join others online on the Infobus (http://www.talktofrank.com). A further service for young people is E-motion (http://www.visyon.org.uk) — a website providing online emotional support for 11 to 25 year olds in South Cheshire. It offers both free email support and online counselling to individuals who, for whatever reason, choose not to use face-to-face services, thereby aiming to increase access. Many other web based services exist for young people.

Many college and university counselling services are using email based services as one option for students unable or unwilling to access face-to-face services. Mitchell and Dunn (2007) describe the introduction of self help computerised cognitive behavioural therapy in a student counselling service. They found the programme to be effective in reducing depression although not anxiety, arguing that 'CCBT may be a viable addition to current provision in Higher Education Counselling Services and that further studies are required to investigate this further' (2007:144). In a report (Scott-Marshall, 2005) from the University of Teeside to the Heads of University Counselling Service Groups (HUCs) it was noted that 'it can be seen that advantages outweigh the disadvantages in term of points, and yet the distinct impression is that email counselling could be considered a difficult option as regards implementation.' Sheffield University counselling services have used imaginative and creative writing as an adjunct to face-to-face counselling (Wright and Chung, 2001), another example of the integration of techniques available through technology with more traditional approaches. It does appear that practitioners who work online with email are

also open to using other modes of communication too: instant messaging, chat, phone calls, as well as face-to-face meetings.

Chat rooms

Chat rooms are where a client 'chats' with a counsellor through the use of an instant messaging system and is therefore a synchronous therapeutic communication. Chat programs exist in which an appointment is made and generally paid for before counsellor and client 'meet' on line, using text based exchanges for a specified amount of time. This is evolving into secure web-based messaging. A therapeutic chat room can involve several participants who are normally pre-selected led by a therapist working to agreed and pre-established ground rules and established boundaries.

Online support groups

Online support groups are considered as a special type of self help (Bellafiore, Colòn and Rosenberg, 2004; Tucker-Ladd, 2000), helping those in distress to find others with similar needs and problems, sharing feelings and information, providing advice, and developing a sense of belonging, camaraderie and community. More than one model exists for their organisation and Hsuing (2000) considers how self help groups online can benefit from having a facilitator. Online support groups have been used increasingly since the mid 1990s and exist for a wide variety of groups and issues. A recent survey conducted by Pew internet Research Institute (2005) showed that 36 million people in the United States alone said they were members of online support groups. The fact that so many exist and that large numbers make contact indicate not only that individuals receive support over the internet but that people are prepared to seek out help in an online environment. They may be a first step to change for many people (Grohol, 2004). Of course, support groups are likely to attract those already comfortable with on line communication and may not be beneficial to many.

Blogging

Blogging is a relatively recent online innovation and Mind Bloggling (http://www.mindbloggling.org.uk) is a positive example of this type of initiative. This is a new project, an online community of blogs, giving a voice to people with

mental health issues. It is a project of The Media Action Group for Mental Health (MAGMH), a charity based in the West Midlands that aims at promoting positive perceptions of mental health by collaborative working with the media and the general public. It provides a safe and anonymous space for people to write what they want in an online journal and also helps users develop skill level. In a personal communication from the organiser Emma Brown she describes the project:

'The mind bloggling team consists of myself and an out-reach worker. Between us, we've developed the web site, maintain the library and run the 'drop-in' sessions, which are held here at the Media Action Group offices. We've also written a training programme to enable people to work independently on their blogs and improve their computer skills.

The vast majority of our bloggers are aged over 40 and had limited knowledge about computers and the internet. Many have been involved with mental health services for a significant number of years. What Mind Bloggling offers is a way of enabling people to express themselves on subjects which are of importance to them. The ethos is about promoting positive mental health; however the content of each post is completely at the discretion of the blogger. We developed a set of ground rules at the start of the project, but this was largely to ensure we remained within the law regarding copyright. The 'drop in' sessions primarily focus on improving computer skills, although they also provide a source of emotional and at times practical support for the bloggers.

There have been many rewards as a result of the Mind Bloggling project. The drawing together of a supportive community has benefited many of the bloggers and their increase in confidence from mastering new technology was perhaps expected. However, the project has also enabled people to publish their artwork, music and videos through the medium. It has also allowed people with few monetary resources to maintain contact with relatives and friends across the world. All in all it's been a great thing for the people involved. There is a desire for the project to continue and from October we are hoping to run the web site using a pool of volunteers.'

As with many projects funding is a key issue in its continuation. Examples of the blogs are given in the section 'User opinion and client examples'.

Creative use of online mental health interventions

For some clients, using one approach, whether it be face-to-face or online, may work well. However as noted the advent of the use and accessibility of technology opens up many possibilities for creatively combining different ways of communicating. Those who have worked with creative arts in therapy know well that people express themselves differently through various mediums and this is so when communicating with voice, text, and visuals. Distinctive aspects of identity and self come into play through these modalities. Moving from one to another form of communication can be an important step in a therapeutic process. Some practitioners may design specific therapeutic programme by combining diverse aspects, whilst others may respond intuitively and organically as work progresses. It is certainly very evident anecdotally that more and more practitioners are incorporating email into their face-to-face work for a variety of therapeutic reasons, and for some clients it is less disturbing to communicate traumatic experiences using distance technology than it is to speak. Online work is sometimes a necessity in family therapy where family members are geographically separated and scattered but written work can be a virtue as well as a necessity. It can further support therapeutic interventions by using written tasks to support treatment goals and aims (King and Engi, 1998).

The therapeutic benefits of writing have long been recognised. Journal therapy was introduced by Progoff (1975) and writing therapeutically has been incorporated into many approaches including cognitive analytic therapy (Ryle, 1990) and counselling adult survivors of abuse (Hall and Lloyd, 1989). Lange (1994, 1996, 2001) has used structured writing to help overcome trauma and symptoms of post traumatic stress. From the 1980s Francis and Pennebaker (1992), and Pennebaker (1997) have explored the role of emotional disclosure in writing and health and Smyth (1998) has carried out a meta-analysis in this area.

Wright (2002) in her exploration of online counselling and how this may be informed by writing therapy explores 'grey' literature, for example unpublished dissertations, as well as published work, noting that 'dramatists, poets, novelist

and diarists throughout the ages have recognised the link between emotional disclosure in writing and emotional health.' (286). Given that writing is widely recognised as therapeutic in itself it is hardly surprising that it has been taken up by online therapists and their clients. It could be asked whether writing is simply therapeutic in itself, by oneself, without an online therapeutic relationship. It is doubtless so for some. That however does not negate the significance for the many for whom an essential element is having a companion to dialogue with along the way (Rogers, 1993).

Murphy and Mitchell (1998) describe how therapy by email begins with clients completing a worksheet (http://www.therapyonline.ca). The client and the counsellor then work together to construct an agreement that plans future email correspondence. Those participating are encouraged to employ narrative therapy strategies and various literary techniques to broaden levels of meaning. Etchison and Kleist (2000) consider how online narrative therapy has benefits and positive effects beyond what is written in the emails. The development of online skills can be further utilised by encouraging participants into undertaking more formal narrative therapy and so online work may be one step in a longer therapeutic journey.

Although using art therapy and image making may seem especially problematic using internet communication there is a growing interest in this (Malchiodi, 2000). Collie *et al.* (2002) describe a computer process that can be used with a group or in one-to-one work whereby members can speak, draw, show drawings to others, whilst also being aware what others are doing. This sounds complex but does not require previous computer experience and according to the authors is learned in under 15 minutes. The participants in this study said they felt freer and less inhibited than when they used ordinary art materials.

Fenichel *et al.* (2003) suggest that group work is developing as an online activity for both educational and therapeutic purposes. For example, professionals work together online to present and discuss cases facilitated by group leaders. Group members gained from working together with three professionals with different but complementary specialties. Although the focus in this report is on online services for clients and patients it is nevertheless important to note that it opens

up significant possibilities for professionals to communicate and learn through using ICT.

Although text-based communication is currently the most common method for conducting online psychotherapy, clinicians have begun to experiment with multimedia approaches. The ISHMO (http://www.ismho.org) notes that practitioners can use virtual environments in which the client and therapist create visual representations of themselves (‘avatars’) in order to interact with each other. This could become useful for psychotherapies involving fantasy, imagination, and role playing.

Do telephone and on line approaches work?

Online provision in particular is of recent origin, so the evidence base is inevitably in the early stages of development and as Maheu and Gordon (2000) point out, the effectiveness of online counselling as a clinical method has hardly even begun to be evaluated. Work that has been undertaken to date focuses on different aspects: projects aimed at particular groups, and specific aspects of the therapeutic process itself (for example, the therapeutic alliance), whilst others look at the process overall. Telephone work has a longer history although Mallen *et al.* (2005) point out that researching telephone counselling is inherently problematic as there is no direct comparison with face-to-face counselling. Some studies do attempt comparison between telephone and face-to-face, or with online approaches. However comparison is only one strand; research need not necessarily compare but can study an approach as a stand alone, in its own right. Many argue that therapeutic work online is simply different, not better or worse and comparisons may not necessarily be helpful (Grohol, 1999b).

Some studies point to telephone counselling being as effective as face-to-face counselling and suggest it is particularly helpful in terms of availability and access compared with face-to-face, and that it is acceptable to clients (Reese, 2004). Telephone interventions have demonstrated good results in treating schizophrenia (Beebe, 2004), depression (Tutty, Simon, and Ludman, 2000) and in crisis intervention. King *et al. (*2006a) in their discussion of Kids Help Line, a free Australian telephone and online counselling for young people, suggest that telephone counselling is associated with better outcomes, higher session impact and stronger alliance when compared with online. This may be because telephone counselling, compared to online where responses are delayed, is a more efficient means of communication in that it allows more work to be done in the allotted time. This was based on young people who had received one session of either online or telephone counselling and it may be that different results would be in evidence if this was repeated after several sessions

Research carried out by SANE on self disclosure explores and compares the amount of self disclosure from those seeking help using internet based services and those using telephone based services. The sample studied were matched in respect of gender, age and types of mental illness and it was discovered that

those using the internet both disclosed significantly more clinical symptoms and information on more sensitive topics than telephone participants. It notes that 'in line with previous research, it was predicted that online participants would disclose a greater number of clinical symptoms than telephone participants but that there would be no difference between the groups in the degree of sensitivity of the topics that they disclosed' (accessed 01.08.07 from http://www.sane.org.uk/Research/Library#2003_SelfDisclosure). This study also looks at research methodology, particularly relating to how to use telephone and internet samples effectively.

Many studies consider whether distance communication between people is as effective as in-person communication (Simpson, 2001; Day and Schneider, 2000; Cohen and Kerr, 1998; Weinberg, 1996). Weinberg's work examines perceived levels of supportiveness and helpfulness and the results indicate that people perceive these aspects positively in online work. Various authors suggest that communication which lacks visual aspects could actually enhance counselling (Anthony, 2000; Lazlo *et al.*, 1999). Anthony (2000) suggests that 'the rapport between counsellor and client in cyberspace is developed not by reacting to another person's physical presence but by entering the clients mental constructs by the written word' (626). Collie *et al.* (2002) conclude 'that people adapt to a communication medium to meet their relational needs' (271). A London psychiatrist surveyed patients with obsessive-compulsive disorder and phobic anxiety disorders and found that 91% preferred receiving services via interactive voice response, the internet, or home computer over face-to-face treatment (Graham, 2000). It has been argued by others that lack of nonverbal communication would be a very significant obstacle to the creation of a therapeutic connection (Banach and Bernat, 2000; Hackerman and Greer, 2000; Sussman, 2002).

On theoretical grounds some are dubious that a sufficient working alliance is possible in online counselling, stressing the potential impact of the lack of nonverbal cues and their significance in communicating warmth, support and empathy However others think differently and Young (2003) cites the widespread take up of online chat using text based methods and how these are used to divulge very personal information and receive back support and

empathy. The research cited above by SANE would support this view as does an evaluation from Kooth (Hale, 2006).

Rochlen *et al.* (2004) argue for a greater emphasis on understanding process variables in online counselling in order to explore more fully this question of alliance. Cook and Doyle (2002) and Reynolds *et al.* (2006) have explored alliance aspects with the latter examining the session impact (measured by the Session Evaluation Questionnaire; Stiles, Gordon, and Lani, 2002) and the client-therapist alliance (measured by the Agnew Relationship Measure; Agnew-Davies *et al.*, 1998) of clients and therapist interactions in email therapy. They compared these with work previously undertaken in regard to face-to-face therapy and their results suggest similar session impact and therapeutic alliance ratings in the two groups. Leibert *et al.* (2006) have somewhat different results: their study surveyed a group of young women receiving online help and compared their Working Alliance Inventory-Short Form (WAI-S) (Horvath and Greenberg 1989) scores with a sample of face-to-face therapy clients. They identified weaker working alliances in the online group although they expressed considerable satisfaction with their online counselling.

In a naturalistic study King *et al.* (2006b) compare the online working alliance to that developed over the telephone. The research group found that it was possible to create a working alliance of sufficient quality to have a positive outcome in both conditions. It was also noted that the telephone saw the development of significantly stronger alliances than online. However, critics of online approaches warn that the 'space between the two parties' becomes filled with nothing but hardware (Robson and Robson, 2000). It is worth debating whether working alliance measures, developed for face-to-face work, are helpful when transferred to online work. The working alliance in online work could be an essentially different process, made up of different components. There is therefore a need to examine differences in significant elements in the process between online therapy and face-to-face therapy (Mallen *et al.*, 2005).

Rochlen (2004a) explored clients' attitudes and preferences and discovered that given a choice most people would prefer face-to-face counselling. However attitudes are likely to be based on familiarity and expectations rather than actual experience. Experience can influence attitudes so a different picture may emerge

if those involved had actually experienced online help. Mallen *et al.* (2005) discusses those who have received online counselling, and reports positive responses concluding that 'thus far research has demonstrated that according to clients self reports they perceive forms of online counselling as satisfactory and useful. It appears that professionals are less likely to accept new modes of treatment … because they possess knowledge and training in the effectiveness of traditional treatments' (835). The attitudes of professionals will be further considered later.

Jacobs (2001) found no difference in effectiveness of computer treatments compared to face-to-face approaches to counselling, and Rochlen *et al.* (2004b) in their review of published evidence, although they point to methodological difficulties overall conclude that when examined as a whole the empirical studies of online counselling provide encouraging evidence of efficacy. However those planning to develop online services need to be very aware that in order to effectively access their target group they must recognise and work with potential resistance.

For whom do ICT based services work?

What follows below is a summary of key areas and themes, acknowledging that these are indicative not absolute.

Online support groups

Research on the effectiveness of online support is mixed. Typically it finds benefits for participants (Grohol, 2004) with some research and anecdotal evidence showing an actual positive contribution of online support groups to their participants (Mallen *et al.*, 2005). On the other hand, there are other empirical studies and case reports (Eysenbach *et al.*, 2004) suggesting that these groups tend to be ineffective. Critics contend there is no clear understanding of the therapeutic effectiveness or even of the appropriateness of using email as a therapeutic endeavour (Maheau and Gordon, 2000).

Although the research is mixed it, can certainly be argued that for a significant number of distressed people online support groups are meaningful and significant, including those who have suffered abuse, are depressed, who have relationship difficulties, or other kinds of personal problems. Braithwaite *et al.* (1999) suggest that these groups are holistic and can empower those who use them. Online support groups are easy to approach; identity and anonymity is assured and therefore they possess certain benefits for those unable to, or unwilling to attend face-to-face sessions.

Crisis intervention

Online is a helpful medium in crisis intervention and in prevention of suicide. SAHAR, the Israeli online crisis service (http://www.sahar.org.il), has demonstrated that suicide can be prevented and severe distress alleviated through online support which it has provided to considerable numbers of Israelis. Part of its suicide prevention strategy has included discovering and responding to last minute suicide notes. A number of websites exist pertaining to suicide prevention giving information and self-help resources. Those in distress can use these sites directly without seeking other help and may be an incentive for seeking further help. As noted previously Samaritans email service has been very successful.

Young people

It was noted previously that the use of computers and the internet is highest amongst young people and this is coupled with high levels of concern about their mental health. It is also recognised that they encounter specific barriers in accessing health services, including those for mental health (Owens *et al.*, 2002). Recent research indicates that the internet is rapidly becoming a major source of health information for adolescents (Gray *et al.*, 2005). Young people are attracted to the internet for help and advice because it is both accessible and anonymous (Nicholas *et al.*, 2004; Gray *et al.*, 2005). The need for effective information and help is horribly evident: levels of depression amongst the young are reflected in the prescribing of antidepressants to children and young people, 'between 1991 and 2001 the number of children prescribed anti depressants in the UK rose by 70%, amid an apparent epidemic of self-harm and eating disorders. An estimated 35,000 children and teenagers are currently being treated with Prozac-type drugs.' (*The Times*, June 26 2007). Research shows that the internet is a key source of health information for young people as they experience it as both accessible and anonymous (Nicholas *et al.*, 2004; Gray *et al.*, 2005) and it could therefore be expected that this group are particularly open to using online services.

The Kids Help Line (KHL) (http://www.kidshelp.com.au accessed 01.08.07) organisation in Australia is probably the most established online counselling services for young people in the world responding to 6,476 real time online counselling clients and 7,354 email clients in 2002 alone. Each week counsellors respond to over 9,000 telephone calls and 500 online contacts (web and email). Overall since launching in 2000 this service has been used by around 50,000 children and young people, with the rate of use doubling each year. Since it began the proportion of online clients contacting for help about mental health, suicide, and eating difficulties has increased threefold and those contacting with issues about emotional and behavioural problems and self-image has doubled. KHL notes that the issues young people discuss online are more complex and severe than those dealt with by the telephone. Those using the KHL online service were positive but some difficulties emerged; counselling sessions being too short, waiting in a queue, and insufficient availability. Of course, these types of service restriction and insufficiency are not limited to online provision.

An evaluation of the Kooth service described earlier (Hale, 2006), show that 91% of young people using Kooth online deal successfully with their difficulties and do not require further support. 89% say they prefer online to telephone support and the use of Kooth online has increased from 1000 registered users in February 2005 to 2260 a year later. On average 356 messages are sent to Kooth counsellors each month and about half of messaging and chat sessions take place outside of office hours.

Hanley (2004a; 2004b; 2006) and King (2006a; 2006b) explore online counselling provision for young people in the United Kingdom. Their preliminary findings suggest that it is possible to create therapeutic relationships with young people online, citing examples such as Kooth and E-motion as examples of projects achieving positive results. Hanley considers why young people might use the internet for counselling instead of using face-to-face or telephone and explores their experiences of online counselling. His study suggests that they feel safer and less emotionally exposed in the online situation as opposed to experiencing vulnerability in face-to-face or telephone counselling. They also experienced a greater sense of privacy, and this is further supported by the work of Gray *et al.* (2005); Nicholas *et al.* (2004) and Young, (2005).

As early as 1976, work has been undertaken on using technology in child and adolescent psychiatry. Straker *et al.* (1976) described the use of a video link between a child guidance clinic and a teaching hospital to facilitate access to a service by families previously inhibited from entering it. They suggest that videoconferencing can successfully make services available to those otherwise excluded for social or distance reasons. Elford *et al.* (2000) evaluated a personal-computer-based videoconferencing system used for remote psychiatric assessments in Newfoundland. Those who used the service liked it with many preferring it to face-to-face sessions, and diagnosis and treatment recommendations were clinically the same as those made face-to-face.

Abuse and sexuality

Constantino *et al.* (2007) consider work undertaken in the USA on the feasibility of an email device called MIVO to help women and children who have experienced domestic abuse. This arose from attempts to identify how technology could help survivors of abuse. Domestic abuse impacts hugely on

mental health and social isolation exacerbates this, whilst social support lessens the effects (Constantino *et al.*, 2005) and this initiative explored whether introducing email support could be effective in lessening isolation and feelings of aloneness. Previous studies have indicated that using e mail can reduce intrusive thoughts and assist people in responding helpfully to their situations. Cohen and Pressman (2004) and McFarlane *et al.* (2002) showed that regular telephone contact with survivors of domestic abuse led to 70% of the women taking positive steps to protect themselves, with a significant difference to a similar group without this support. In this study described by Constantino all the mother and child pairs emailed at least once a week. They managed the programme with no difficulty; gave positive feedback, and results indicated that email is workable and acceptable in providing information and support to this group.

Many survivors of childhood abuse report that they feel too frightened or too ashamed to see a therapist in person, at least in the initial stages of their healing. Abuse takes place in secret and the confidentiality and privacy of therapy, and being in a closed room with one other person, can paradoxically and unintentionally replicate the abusive scenario. Perpetrators of abuse are often those deemed by society to be trustworthy, in the same way it deems practitioners trustworthy. For all these reasons and many more seeking face-to-face help can be highly problematic (Walker, 2003). It is also well recognised that there are particular issues for men seeking help, where the shame intrinsic in abuse is intensified by gendered expectations (Grubman-Black, 1990; Bolton *et al.*, 1989). It is less frightening for many such people to receive therapy online from the safety of their own home. However there is another side: some abuse perpetrators use the internet to post pictures of their victims and use it to organise abuse. Survivors caught up in those scenarios may see online services as potentially dangerous and open to exploitation.

Lesbians and gay men, particularly those in the early stages of dealing with their sexuality who may not yet have come out, and who may fear being judged, can find online therapy less threatening. Clients needing to talk about sexual issues can feel uncomfortable meeting in person, and feel easier discussing this with a therapist online. Additionally, if there is real concern about confidentiality this can feel safer than a therapy office where they could see someone they know, or could be recognised as gay by seeing a therapist specializing in working with gay

clients. This is especially pertinent for those living in rural areas and in small communities where accessing face-to-face help anonymously is problematic. For those clients where shame, fear, and secrecy are significant, and this is often the case where issues relate to abuse and sexuality, the privacy of therapy online can be attractive (Shernoff, 2000). DeAngelis (2002) explores further this interesting question of how counselling services can be provided for a population at risk of discrimination.

Eating disorders

Mallen, *et al.* (2005) have reviewed studies of online therapy for eating disorders and their outcomes and their findings suggest that these can be an effective method of treatment. Interactive online chat and other online approaches may help treat women with eating disorders or at risk of developing them (Zabinski *et al.*, 2001, 2004; Robinson and Serfaty 2001, 2003; Tate *et al.*, 2001). Robinson and Serfaty compared three months before and three months after treatment, a group of British women with eating disorders randomly allocated to consultant psychiatrists, one who practiced face-to-face the other by email. They conclude that email therapy may be a useful treatment for bulimic disorders as symptoms reduced significantly. Yager (2001) reports how using email was effectively used as an adjunct in treating anorexia nervosa and notes that patients reported this is helpful and easily accepted its use.

However, researchers for SANE have produced a significant report (Csipke and Horne, 2007), in which they examine a specific aspect of online provision in relation to eating disorders, those who visit what they describe as 'pro-eating disorder websites'. This is a relatively new phenomenon whereby 'pro-ana' sites, for anorexia, or 'pro-mia', for bulimia, can be accessed and, for example, 'Tips or Tricks' on maintaining and hiding disordered eating can be found. Most commonly these sites are hosted by people with an eating disorder.

Csipke and Horne found those using the sites were mostly young and female, some as young as 13 and the majority 22 or younger. They visited the sites frequently, 41% several times a day. Although those using them most frequently reported positive effects improved self-esteem, feeling safe and in control, feeling better about themselves and feeling less lonely negative effects were

reported, for example weighing, measuring, fasting and purging more often after visiting the sites.

70% of those taking part in the research reported suicidal thoughts or feelings and 46% self-harmed demonstrating how these sites attract a vulnerable group. Csipke and Home are concerned that these sites support damaging behaviour rather than encouraging treatment being sought and have called for those publishing the sites to review their content and for Internet Service Providers to remove them. Clearly this work introduces complex questions into any debate about the helpfulness or appropriateness of online interventions. It is a significant piece of work in alerting to dangers as well as possibilities and to highlighting whether self perceptions of helpfulness sometimes need further consideration.

Addictions

In its report on gambling, the British Medical Association (BMA, 2007) called for gambling to be a recognised addiction requiring NHS treatment. Problem gambling is associated with many health problems including anxiety, depression, guilt, suicidal thoughts and relationship breakdown. Just less than 1% of the British population have a severe gambling problem, although the rate is about twice as high in adolescents, a result of slot machine gambling (Sproston *et al*., 2000). Griffiths and Cooper (2003) point out that online interventions are particularly suitable for this group. Crises with gambling are likely to occur out of office hours and online services can be available at any time, unlike obtaining help from mental health practitioners. They also suggest that gambling carries a stigma as it is perceived to be self initiated problem and that 'online psychotherapists offer a degree of anonymity that reduces the potential stigma… the issue of stigma has caused some problem gamblers to avoid seeking treatment' (122).

Hall (2003) in her study of those using an online recovery service argues that such services have special impact for people who abuse substances and are used both by those with addictions and family and friends who are affected. She argues for the widespread and free provision of e-technology for those suffering from addictions. She states that 'Inpatient and face-to-face treatment providers will always have a place in addiction services, but for those who find traditional

services inaccessible there is an alternative. Online peer support reaches those who are geographically isolated, physically challenged, or socially unable to access face-to-face services' (164). Her study suggests that to reach its full potential for assisting addicts, online provision should include email support groups, electronic bulletin boards, real-time internet meetings, and real-time peer group support chat rooms. This study is another that stresses the funding difficulties experienced by many projects and makes a plea for ongoing funding that is sufficient for purpose.

Prisons

Many prisoners have complex mental health needs and yet the vast majority receive a lower standard of mental health care than the rest of the population (Singleton *et al.,* 1998) although entitled to the same. A systematic review shows one in seven prisoners has a psychotic illness (Fazel and Danesh, 2002). Telepsychiatry is one strategy to improve accessibility and quality of mental health care in prisons.

Experience from prisons in the United States 'indicate that moderately to severely ill inmates with a broad range of psychiatric illnesses can be seen and treated effectively using a video conferencing system' (Zaylor *et al.,* 2000: 463). This study further shows that psychiatrists and prisoners are both satisfied with the system and that the demand for consultations was five times greater than projected and rose to 34 consultations per month.

Leonard (2004) describing a project in the United Kingdom indicates that telespychiatry was readily accepted by prisoners. He also notes that 'spending time with each individual and familiarizing them with technology appeared to reduce anxiety levels significantly' (466). This is an interesting observation and one made in respect of other projects (see comments below on 'Beating the Blues') that introducing a real person into the technological equation can make the process more acceptable. In Leonard's study no prisoner refused to use it and no-one walked out.

Anxiety and Depression

There is growing evidence that computer delivered self-help is effective for treatment of anxiety (Cavanagh and Shapiro, 2004) and depression (Christensen

et al., 2004). Eisdorfer *et al.* (2003) found that depressed people who had participated in a supportive group online found this a helpful experience, providing support, information and treatment alternatives and a place to share feelings. Certainly computerised cognitive behaviour therapy is increasingly attractive in mental health care by reducing waiting lists for mental health interventions, and because of its accessibility. NICE guidelines (2006) indicate it may be of value in managing anxiety and depression. Unlike some other therapeutic approaches CBT is straightforward to computerise as it is systematic, rather than responsive and reactive to an individual client. Some studies show that people reveal more to a computer than to a therapist (Fowler, 1985), and Newman *et al.* (1997) show that drop out rates in computer delivered and person delivered therapies are much the same. Kaltenthaler *et al.* (2002) suggest there is growing evidence for the effectiveness of computerised therapy; Cavanagh and Shapiro (2004) shows face-to-face and computer delivered CBT having an equivalent efficacy; Anderson *et al.* (2005) in a randomised control of internet based CBT show it to be effective in reducing depressive symptoms, whilst some argue for further trials to show effectiveness (Christensen and Griffiths, 2002).

'Beating the Blues' can be used in GP's surgeries requiring five minutes of practitioner time for each session. It consists of nine treatment sessions of 50 minutes and therefore in terms of cost and accessibility is likely to be very appealing. Van der Berg *et al.* (2004) suggest that key to its success is effective support being given to the clients using it, but note that this can be provided by trained administrative and secretarial staff. Self-reported ratings for those who completed show statistically significant improvement in anxiety and depression as well as in work and social adjustment compared to those receiving GP treatment. These improvements were maintained at 6 months. 'Fear Fighter' is another computerised package and Kaltenhaler *et al.* (2004) describe a randomized control trial (RCT) that supports its efficacy.

White *et al.* (2000) studied the effectiveness of a computerised anxiety management programme for long term sufferers of anxiety disorder living in an area of high social deprivation. A six month follow up indicated it had been welcomed by patients and been effective. White (1998) describes how a computerised self help package for anxiety disorders (Stresspac) produced

significant improvement. Feedback from patients showed that they valued understandable and relevant information and felt it enabled them to regain control in their lives: 'there is some evidence that patients are using the computer and handout to control their own problems once the therapy is completed. Online therapy has also proved to be helpful in treating panic attacks (Cohen and Kerr, 1998; Klein and Richards, 2001; Kenright and Marks, 2001) and post traumatic stress disorders (Lange *et al.,* 2001).

Advantages and disadvantages of on line approaches

Advantages

Some of the advantages of online services have been mentioned previously, in particular how stigmatised groups or those who are frightened or shamed may prefer the privacy of online work (Lange, 1994; Pennebaker, 1997), but others are also in evidence. Clients can save emails, chat transcripts, and other online exchanges and use them to practice and reflect on the therapeutic messages they contain. This can be both grounding and provide opportunities for reality testing. They have a record of work undertaken that is a reminder of progress made, or that can provide reassurance if feeling distressed or uncertain. Lacking visibility could be advantageous too: it removes concerns about appearance and how the other may react when seeing and hearing them. This is an interesting parallel to traditional psychoanalysis, with the analyst sitting out of view unseen behind the patient, encouraging saying anything without feeling inhibited by the analyst's reaction.

Writing provides freedom for the person to define their experiences, choose what is relevant to explore, and proceed at their own pace (Bolton, 1999a, 1999b; Cohen and Kerr, 1998; Collie *et al.*, 2000; Rasmussen and Tomm, 1992). The asynchronisity of email counselling gives client and counsellor time to reflect on their responses, and the opportunity to express these clearly (Lange *et al.*, 2001; Murphy and Mitchell, 1998). For others, the gap between responses can be worrying — a good example of how an advantageous feature for some can be the opposite for others. Clients also become more active participants in their own healing although many working offline would of course argue that this is equally possible in that modality. Clients can log off if they wish to and no-one knows their identity or where they live. In these ways they are in charge of the process: they have more control of the therapeutic relationship, an aspect of online work echoed by many. Many feel that receiving help online also enables greater ease and speed in expressing feelings (Esterling *et al.,* 1999; Lange, 1994). Grohol, quoted in Dunaway (2000) suggests that people are more disinhibited on the internet than in real life. Baughan (2000) gives credence to this argument from the work undertaken by the Samaritans.

Addis and Mahalik (2003) support the view that men with difficulty expressing emotion responded more favourably to online counselling. Samaritans also note that there is greater potential for young male users to use online services (Baughan 2000). Their service attracts large numbers receiving 25,000 email contacts in 1999; 57,000 in 2000. A majority involved depression and suicidal thoughts, primarily from a population of young men aged 18–24, the group least likely to attend face-to-face counselling or even admit to experiencing personal difficulties. There is similar evidence from other studies that men may more easily communicate online especially to talk about sensitive issues like depression or suicide (Spinney, 1995; Salem *et al.,* 1997). Online interventions may be used as a stepping stone into a therapeutic process and can lead and evolve into other forms of therapeutic help (Zabinski *et al.*, 2004; Weinert *et al.*, 2005). Email technology enables practitioners to provide a range of services: advice, consultation, education, and direct care to clients living in remote areas (Jerome *et al.*, 2000; Weinert *et al., 2*005).

Online support groups have many advantages (Finn, 1995, 1999; Madara, 1997). Bacon *et al.* (2000) describe a service to assist young widows which combined private weekly online chats and email correspondence. Participants described the advantages as decreasing isolation, providing opportunities to share experiences with others in similar circumstances and being given emotional support and coping strategies. They note that with asynchronous communication, participants have access at all hours and can use them when needed and when convenient. Obstacles such as geography and the need for available transport do not exist and those with mobility, speech and hearing difficulties, other disabilities, or those who are restricted in accessing services by caring for others are not excluded. People who travel extensively for work, or who have family and personal commitments, may choose online therapeutic services because they can be accessed from anywhere. Lange *et al. (*2001) and Murphy and Mitchell (1998) argue that the existence of online resources provides a greater and less stigmatised choice.

Practically speaking then, online mental health resources of various sorts offers accessibility and convenience to many clients. In terms of fee paying services costs are usually lower for clients as overheads are lower and travel costs are nil. The lack of travel requirements improves access for many, and those who

are ambivalent about receiving help may find it easier and more acceptable to access assistance online. Because of the range of services people are able to search and research online therefore extending the choices available to them.

Disadvantages

To use any technology based services access to a computer and to the internet is usually needed (although mobile phones can be used to access some, there are cost implications for this) and in global terms this eliminates much of the world's population from participating (Office for National Statistics, 2007; Braithwaite *et al.*, 1999; Madara, 1997). As noted earlier the 'digital divide' still separates the information poor, particularly the economically poor, minorities and older people, from those who can afford to pay (Galinsky *et al.*, 1997; Madara, 1997). Although in the UK public internet access is available in many areas and often in the workplace, provision is not universal and accessing services publicly or at work has privacy and confidentiality implications. Even having a computer can have its own problems as technical problems can be many, from minor disruptions to complete disconnection. For example a system crashing in the middle of a session can leave someone feeling abandoned by the group (Collie *et al.*, 2002).

So, for example, although this type of provision can help overcome the isolation of disability, a thorough technological assessment needs to be carried out. Technical problems must be identified and resolved, to avoid the same sense of isolation being created by a different route. The sense of control described previously as an advantage is negated if systems crash or major technical difficulties occur. There may be non-technical disadvantages too: lack of shared physical presence can feel uncomfortable and lacking in real, human connection for some with Rosenfeld suggesting that 'increasing human connectedness is a key ingredient of healing, and … online counselling/therapy is to condone the separateness between people that many therapeutic interventions are aimed at repairing' (Rosenfeld 2000: 279). Both Lago (1996) and Griffiths (2001) echo this view and Bacon *et al.* (2000) noted the lack of physical presence and touch, the possibility for misunderstandings to arise, and the overwhelming volume of email as negative aspects of their group. In the study by May *et al.* (2000) on GP's responses to using technology to provide mental health services some of

the disadvantages identified were that it makes patients and professionals anxious; it is harder to reassure patients; non verbal communication is significant and would be absent, and the quality of the professional relationship would be compromised. 'Flaming' has been identified as a disadvantage and potential problem, that is the sending of highly emotionally charged messages, which may be hostile, a negative aspect of the impact of online work on inhibitions (Oravec, 1996; Turkle, 1995).

The actual process can also produce difficulties. For example, in groups if procedures and guidelines are not firmly and clearly agreed and in place problems can arise. When people are not seen it is not possible to know if they are there or if they have left, so agreement to announce presence and departure is important. Similarly if people do not identify themselves before they speak confusion can be created. Both in online and in telephone work there is no way of knowing who else may be in the room; whether this is compromising the work being undertaken, or even creating a dangerous situation for the client. Neither can it be known how the client uses any recordings of session material. Rosenfeld (2000) points out that in the context of telephone counselling silences seem much longer than in face-to-face. It would also be over simplistic to regard online services as necessarily cost cutting as it can take considerable time to respond to complex client communications (Lazlo *et al.,* 1999). Asynchronous communication whilst providing time for reflection can also trigger anxiety as delays in response may be uncomfortable and worrying.

Other potential disadvantages are that unqualified individuals may take advantage of vulnerable people. Pelling (2001) suggests that it is difficult for clients to know if online counsellors are legitimate, although in the UK context where currently counselling and psychotherapy remain unregulated this seems a similar risk to face-to-face settings. Accessing online help may prevent those with serious disturbance getting the level of service they need although conversely online services may reach those otherwise excluded. Effective screening and assessment could potentially prevent this, but the difficulty would remain unless the profession itself is effectively regulated.

Professional aspects

Bloor *et al.* (2002) point out that those working online need to be aware of two key aspects: technical issues and considerations, and codes of conduct. Wright (2002) state that 'the Samaritans UK based experience and research and practice from North America would indicate that special skills are required for online counselling' (293). Mallen *et al.* (2003) also point out that communicating effectively using technology takes time and practice. Hanley in his 2006 study notes that regulation is a major concern, that there are crucial questions relating to training people for online work and ethical issues that need careful consideration. On the basis of his projects he describes suggest guidelines useful for those setting up new services.

The ISHMO (2000) also states that those providing services over the internet need specific training including technology, theory, applications, and ethics and that this should be undertaken in the same way as training in traditional approaches. Online mental health practitioners need an initial relevant core profession, for example social work, counselling, psychology or psychiatric nursing. If they are offering specialist services, for instance addictions or eating disorders they should have the requisite specialist knowledge and supervision. At the same time their technical skills must be sound. It can be isolated and isolating work and workers need sufficient support to manage this.

A crucial area is whether or not online working enhances or damages the therapeutic relationship (Wootton,1996). This question remains very alive and work continues. As Caspar (2004) discusses it may be horses for courses. Online work is simply not the same; the therapeutic alliance and relationship may therefore take on a different form and shape. Indeed as knowledge and experience develops each therapeutic approach will need to consider whether it is suitable for online work and develop appropriate protocols. Lago (1996) asks whether theories of email counselling need to be designed that are substantially different from non computerised approaches.

There is some evidence that clients are more able to adapt and react positively to online alternatives than are those providing services. Stjernsward and Ostman (2006) question the role mental health should take in relation to mental health and technology: 'Is it mental health care's responsibility to adapt its treatment

alternatives to the prevailing technological trends in society? What ambitions does mental health care have when it comes to the potential benefit of this technology and breaking new grounds within the health care system?' (702). McLaren (2003) suggests that mental health professionals are in the early stages of recognising the potential of technology and that professional aversion sometimes in evidence is not shared by patients. Van der Berg *et al.* (2004) in a study of 'Beating the Blues' talks of mixed responses from both staff and clients with clients' views on the program varying widely, from 'I need more than a computer', to 'I'll give it a try' or even' I like not having to talk to another person about these problems' (510). Mallen *et al.* (2005) conclude that 'thus far research has demonstrated that according to clients' self reports they perceive forms of online counselling as satisfactory and useful. It appears that professionals are less likely to accept new modes of treatment … because they possess knowledge and training in the effectiveness of traditional treatments' (835). They continue, 'research should investigate the possible disparity between clients' desire for and acceptance of online counseling and professionals' lack of acceptance of online counseling' (836).

Inevitably there may be a professional defensiveness that comes into play. Professionals have invested hugely in their own training, are committed to their jobs, and ventures into new technology can be threatening to their skills and may make them fearful of becoming superfluous. Informal discussions with practitioners suggest another anxiety — that the use of technology in mental health services is an attempt to cut corners, reduce costs, to appear to be responding to a major problem whilst in reality not doing so. They feel, in essence, that there may be more image than substance in these initiatives and one referred to 'quick and dirty research' being used to assess CBT online which she felt could challenge the apparent positive results. These concerns may be reality based or may not, but they are real and if services are to become more ICT based they must be addressed. Others express real anxiety that many technology-based services are projects with time-limited funding that depart as quickly as they come even if they have achieved good results, or that they are an attempt to provide a quick fix to human distress that is deep seated and requires in depth responses. For many this is part of a wider concern over modern day initiatives, that it, that they do not have the opportunity to ever

fully develop because they are not sustainable as funding is not long term, and they do not accurately reflect the level of the problem apparently being addressed.

Ethical issues and guidelines

There is considerable concern to identify and resolve ethical issues (Graham, 2000; Griffiths, 2001, Robson and Robson, 2000). Verifying a client's identity, assessing for risk, knowing the client's age, issues of confidentiality, accessing appropriate help if a crisis occurs, and guaranteeing privacy are frequently mentioned as issues. Secure chat rooms, digital signatures and encrypted email are all possible solutions to the confidentiality issue: technical means need to be undertaken to ensure as far as possible technical security. One issue is that email or the computer may be accessible to others. It is clear that such aspects always need addressing with potential clients

Segall (2000) argues that online counselling is as safe as face-to-face work in that both are very confidential but neither is perfect. Segall points out that clients can be seen going into a therapist's office, sound proofing is not always good, filing cabinets may be accessible to others and are not always locked, and that many nowadays keep records computerised. As noted above the appeal of online work for many is that they are perceived as far more private and the very anonymity of online services has clearly enabled life-saving services to be provided to some. There are therefore two aspects to the questions around identity, safety and assessment. Even in face-to-face work it can sometimes be impossible to know precisely someone's age: for example, if a young person declares themselves to be 18 in many instances it is hard to verify this.

There are undoubtedly some inherent ethical risks in using email including messages not being received, or being inadvertently sent to the wrong address. Using passwords and requesting receipts can help but hacking remains a risk. Counsellors should explain both risks and preventative measures taken. As with working face-to-face online practitioners need to provide accurate and appropriate details of their own qualifications and describe the parameters of their work so that informed consent can be obtained. For example the contract needs to include length of response to be expected, how long the client might have to wait for a reply, whether the client can make contact outside of the

agreed frame, how and how long session material is kept. All of these have parallels in face-to-face work. It can be argued that if the work is undertaken responsibly, with the counsellor putting as many safeguards into place as possible, and the process transparent and risks explained the adult client must be allowed the autonomy to choose.

Goss *et al.* (2001) describe how the current lack of substantial research makes professional associations cautious about online practice although many more writers are now considering ethical principles and practices (Elleven and Allen, 2004; Hsiung, 2001; Anthony and Goss, 2003; Goss *et al*., 2001; Anthony, 2003; Goss and Anthony, 2004). Many associations have produced guidelines and codes of ethics for practitioners providing internet based counselling services. Because guidelines address areas specific to internet practice and new technology and new services come into being continually they are likely to need constant review and revision. Associations providing guidelines include the Australian Psychological Society, the American Counseling Association, the American Psychological Association and the British Association for Counselling and Psychotherapy.

The American Counseling Association (ACA) Code of Ethics and Standards of Practice says that 'clients should be intellectually, emotionally and physically capable of using whatever computer application is used in treatment and that the application is appropriate for the needs of clients.' (ACA 2005:6) (http://www.counseling.org) and provide detailed guidance for using technology ethically. Guidelines from the BACP are intended to provide a framework for both users and therapists wishing to offer an online service. They recommend that clients looking for internet counselling check that the therapist is suitably trained and supervised, that they understand the contract they are agreeing to and the limitations of the service they are receiving. In line with many others they indicate that online counselling may require specialised training and experience: 'BACP strongly recommends that practitioners undergo further specialist training in text based online therapy. Such training should incorporate theoretical, practical and ethical considerations of online work' (Antony and Jamieson, 2005:3). The BACP notes that the number of sites offering online counselling services is vast, as can be discovered by searching for 'online counsellor.' Mclean, in guidelines published by the Telephone Helplines Association

(http://www.helplines.org.uk), alerts counsellors to the complexities of offering online services, including time and costs: 'our tendency to write more slowly than we speak can make the cost of written responses higher than that of verbal ones' and notes that several exchanges may be needed before issues are accurately identified (2006:11). Most guidelines and codes cover areas of practitioner competence, training, potential clients, contracting, complaints, confidentiality, referrals, insurance, as well as providing some example case studies.

User opinion and client examples

The following client stories give their source, are presented as written without alteration to spelling, punctuation or structure, and their words are allowed to tell their own stories.

'Can online therapy ease depression?' Emma Wilkinson, Thursday 5th April 2007 http://news.bbc.co.uk/1/hi/health/6442191.stm (accessed 20.07.07)

This article posted on the BBC News website quotes from a patient asked by her GP if she would like to try the 'Beating the Blues' trial after being signed off work with stress. The patient described herself as having got to the point where she was unable to function. She says:

'It was horrible, you just can't control your feelings and you don't know how to get out of this black hole you're in. The online CBT was absolutely brilliant, you learn how to cope with something that previously had seemed insurmountable.'

Another patient had ten sessions of 55 minutes using the same program with the adjunct of the therapist talking her through said:

'One thing she told me was to think of a photograph of something that makes you laugh and when you feel stress, you picture the photograph. You also have a saying that is personal to you, like a mantra, and that will bring you back from slipping backwards into depression.'

Following the treatment she was able to begin the process of ceasing to use antidepressants.

Barak and Dolev-Cohen (2006) in their of study online support groups for distressed adolescents give an example of a message posted by a participant which demonstrates the importance and emotional sustenance of a support group:

'I arrived here lacking self-confidence, depressed, and socially anxious. I thought about committing suicide and finishing with this life. But people here have changed my mind, the way I look at life. With your help and support I've changed to a happier person. I've almost fully overcome my lack of confidence

and social anxiety; I don't think of suicide, it doesn't even cross my mind any more. I've found a really good girlfriend, I began talking to a friend I'd always escaped from, I've generally begun talking to people. And this is all thanks to you. So, again, I want to thank all of you, and hope what happened to me eventually will happen to all of you' (539).

Saneline website (http://www.sane.org.uk/SANEline accessed 20.07.07).

'Thank you SANEline for being my lifeline. I don't know how I would have coped this year without you at the end of the line.' And ' It's hard to imagine the pain caused by mental illness. SANE offers a lifeline of hope and support to people in time of crisis'

Samaritans (http://www.samaritans.org/talk_to_someone/email.aspx accessed 25.08.07); users' comments on the email service:

'When I needed anonymous release the Samaritans were there. I could never disclose these feelings to anyone else. Thanks so much for listening when I felt such deep pain.'

'Someone was prepared to listen. It also helped me think things through by writing it all down and the fact that someone was prepared to read it and effectively listen...helped a lot.'

'I knew that there was someone there to listen and not judge me. The email option offered me the chance to talk when i could'

'It was nice to be able to write my feelings down and no one telling me how stupid i am.'

Mindbloggling (http://mindbloggling.org.uk accessed 26.08.07). These are reproduced with the permission of the bloggers and where identified their blogging names have been used.

From a blogger:

'I'm not doing too well at the moment (what's new eh?). Things have really been getting on top of me lately…. I'm getting sick and tired of being sick and tired if you know what i mean! It's good to know that people are rooting for me and

care when i'm not well, but it's still hard to get out from under that duvet. I haven't posted for a long time but i thought i would make the effort, and it has made me feel a bit better doing this blog. When i'm back at home i will get looking at other peoples' blogs and make some encouraging comments. Take care my fellow bloggers and stay positive’

From ‘klahanie’:

'I will not 'surrender' to my symptoms. I give myself permission to be positive. I try to live my life with positive anticipation. I refuse to let negative speculation overwhelm me. We all have the right to peace and contentment. I want to give others positive affirmations. I am not daunted by my loneliness. For in my solitude, I have discovered a determined resilience. I care passionately for people who have been undermined in an unjust world. I challenge the stigma that still surrounds mental health issues. I will do whatever it takes to reduce the unfair labelling of decent people who have been subjected to a negative environment. I am not ashamed of who I am. Everyday I have to challenge myself. I battle with my 'inner-chatter'. Opposing forces in my mind.One force says: "go out and face the world", the other tells me to "hide under your duvet".To open my door and face the world beyond, is in itself, a personal triumph. I know that there will be those that read this that wont understand. For those that do, they will know that my triumph is no exaggeration. I take a deep breath, determined to suppress my negative 'chatter'. Waves of anxiety nearly overwhelm me, I work through it. The negative 'screaming' becomes a background 'whisper'. I go out and the bravado begins.

I try to be sociable, I reach out my hand of friendship but I am scared, so very, very scared. I worry that my sincerity will be treated with suspicion. I worry that I have said the wrong thing. Renewed anxiety kicks in when I believe that my enthusiasm is interpreted as arrogance. My enthusiasm masks the 'bowl of jelly' sensation deep within me. So for the few hours I go out, I confront my social phobia.

When I finally get to know people, when they become familiar with me, sadly, I retreat back into my 'shell'. I 'fade away', drifting back to a self-imposed obscurity. Unfortunately, I start to think: "how dare you try to be friends with

anybody. You are not worthy of friendship!" People will, once again, see me for that 'imposter' who is not as clever as he makes out. Oh how I challenge this. I must not let past negative, traumatic events dictate that I retreat to the safety of my duvet. I do want to repeat those times when I stayed in bed for days, too ill, too scared to even contemplate going outside.

So after another day of bravado. I go home, mentally exhausted but pleased, that for a few hours, I had the courage to be a part of society. I stare at the four walls and think how my life is so different within the confines of my home. This is my other world. A world where loneliness dominates. Yet it is also a place where I reflect upon my continued journey in maintaining positivity. I must not give up.

I do not want to fall 'overboard' again. In the past, when I fell off the ship, I was thrown an anchor. Somehow, I just know, that if I do fall overboard again, I will be thrown a lifejacket.

Another posting reads:

'In quite a reflective mood of late, and so i just wanted to share with everyone just what the mind bloggling project means to me....

i had never blogged before the project and so, at first, it seemed quite an alien concept to me to have a space online because well....

what would i write?

what might people think of what i write?

have i got anything worthwhile to say that others will want to read?

where do i start?

and the list goes on......

so i just got on with it and put anything down that sprung to mind, and as a

consequence i've learned that i can write what ever is in me to write, and whether anyone finds it interesting or not is not the purpose for it being there, but it is important simply because it is important to me and that therefore makes it important enough to be there. everyone has the right to be heard.

i use my blog as a catalogue of things that i have done, its a positive reminder and inspirational diary of good times, something to have a look back on when i'm feeling a little lack luster.

most importantly though i think that what matters most to me about the mind bloggling project is that it has allowed me to speak with, and connect with such genuinely kind, supportive, interesting, humorous and inspirational people from all walks of life, that ordinarily i may never have had the pleasure to meet.

so that's all really, that i can think of for now, although i am sure that there are many other things that i haven't even crossed my mind.

From Kooth evaluation report (Hale 2006)

1. 'yeah thatd be good i need to put things behind me and carry on.and i need to stop feeling down and upset.thanks for your help today'

2. 'got that cll today of a caseworker thank you for dong that for me i really apreciate i wel i sarted schol on tuesday ad it went quit wel apart from he secon day was a nghtmare because all i could think about was my problem but then i waited till th end of the lesson an had a word wit my teacher and she understu wh i was pset in her lsson and she actualy said that he was going to ri my um because she asconcerned hat i was geting relly pset she did ring the ext day and my m spoke to her nd my mum i am alowed to go nd speak to my techer anytime i want she sid so that help a bit thank you agin i realy ppreciate it'

3. 'hey just a qick msg to say thank u so much 4 helpin me over the years i cant put it in2 words hw g8full i am u will always b deep in my hart n thank u 4 not givin up on me when times was bad, u have made me a stronger im just gonna try my best with my conclor n go all the way. n with my nana n dad yeah it hurts soooooo much but hey what can i do i cant change them iv tried 4 so long

n its killin me so im gonna av a break from my nana n dad n just try n get my self better fully n maby in a couple of mounths i would have stoped self harmin thank u so much hun write bk'

4. 'hi im so sorry i 4got. i went 2 see a counciler the other day n it went ok it was just an assesment but now i hav a counciler n im seein her on wednesday. thanx 4 ur help and advice so far sorry again'

5. 'Hi things have been going really well since we last spoke, I have stopped taking my anti-depressants a week or two ago Well things have been really moving on, told my parents that I am +ve and got a really good response from all my family, and they are giving me the support that I have needed for so long. College is going well, f**ked up a little on course work, but got a letter off my doctor so they are letting me do my last 2 assignments again to get higher grades like I got on my other 2(merit and distinction!)I went in to see Central Youth and it just felt good to talk to someone face-to-face and get things out in the open, so she is going to get back to me when they have some appointments. I am still smoking the dope, but I am happy with that at the minute, I am going to stop one day, and as all these stressful situations are becoming less and less, and my mother is really going on at me now she has found out I am +ve to stop the weed and the ciggys

Anyway, I just wanted to say thank you, it really meant a lot that you was there when I really needed someone, it seemed like I would never get out of the hole that I had got myself into, and so pleased to say I can see the light at the end of the tunnel god knows where I would have been if it had not been for you.'

6. 're chat we had I would like to thank you for giving us a new room as we talked about and I hope that the young people on the site will beable to get some thing ansewer about there sexuilty as since i came on here i have seen a fwe responce off other users that are gay or I have posted telling people that i come on here most days and i will try and respond to as meny as i can I know that I cant respond to them all (ie the grils)thank you'

Evaluation of Email Counselling Pilot Project (Scot-Masters, 2006)

These are examples of client feedback from an email counselling project at Sheffield University:

'To me, I found email counselling much more useful than face-to-face.'

'When you have a problem often you are too scared to talk to someone face-to-face and this system helped me a great deal. I was helpful in giving me some positive options as to how to deal with my problems, instead of just hiding from them. It offered a way to seek help when I would otherwise have been to scared to.'

'The views of an independent practitioner were valuable when my view on things was skewed by emotion and confusion.'

'I never really got into it, because having had face-to-face counselling I thought email might be better as I could formulate my responses better. But I was 'linked' with the same face-to-face counsellor who wanted me to explain everything in detail again. I found it quite patronizing.'

'It was a chance to talk to someone without having to see anyone face-to-face.'

'It allowed me to talk about things that were bothering me without being embarrassed, and it gave me a lot more self confidence.'

'Could answer in own time. Could think about questions, what I wanted to say etc. Wouldn't have to walk home looking sad/been crying etc.'

'I would have preferred to speak to a woman. I felt the counsellor couldn't really understand why I was upset. This may have been because he is a man.'

'i did not use email in the end, i felt i needed a physical person to talk to me with out delay.'

'I was able to talk about a large amount of issues that I was unable to talk to other people about, this was very helpful.'

My Life as an E-patient (Ainsworth, 2002 :198)

'My heart stopped as my email inbox came up. Yes! There it was:
Subject: 2 emails from the cyber-clinic
With some trepidation, I opened the email. I remember scanning the text quickly. Two sentences seemed to leap from the page:
I am here for you and will try only to help.
I am very concerned about you.
With those two sentences he completed the circle.

He had heard me and grasped my pain; he had responded with caring. My human
need cried out and his human compassion responded. It was connection.
Physically, we were separated by five states; but psychically, we were more connected than if we had been in the same room.

In that moment, a relationship came into being that grew into one of the most profound I have ever known.

No longer was I sending my innermost thoughts into a black hole in cyberspace. I felt a living strand of connection between myself and another human being who, although he was several states away, was beginning to create a presence as close as my own thoughts.
Because I had no physical manifestation to which I could relate, he existed inside my own head, to be carried around with me throughout the day. I felt totally connected to him - to this caring presence I had never seen in person."

And:

Our correspondence continued for over 2 years. My e-therapist was faithful, and his caring for me has never wavered. I was challenged, comforted and empowered. The experience was profoundly healing, and my life changed for the better.
I now have a wonderful, deep, trusting relationship with another very gifted loving therapist, with whom I meet in the traditional way, in an office for

weekly sessions. But as close as I am to him, there are still things I cannot say when I am in his presence. When I have something very difficult to talk about, I return to the private, shielded, non-visual connection of email' (202).

Areas for further research

As this is an area of rapid expansion and one that is of considerable interest to academics, policy makers and practitioners there is a considerable amount of research being undertaken. Research into technology and mental health is very much a work in progress, reflecting the field itself. There are however areas that could valuably be considered more fully.

Service user opinion

This is arguably the most important and central aspect for further research: what do clients and service users want and need from mental health services and to what extent can this be met by technological innovations in service delivery? As noted in the executive summary existing research and evidence in this area should be incorporated into service planning but further information is needed from mental health service users. Crucially, it is vital to access those silently suffering often extreme distress who desperately need services that do not exist, and who rarely find a voice through research projects.

A further group that needs careful study is those who drop out from programmes such as 'Beating the Blues' and another is those who will not consider them. Proudfoot *et al.* (2003) discuss the use of 'Beating the Blues' in Doncaster, one of the pilot areas. In one centre they note that 45% of those who started do not complete the programme. This may mean it has not been successful for this group, or they may have stopped because they felt better but whichever it is vital that drop outs are studied. It is important to know more about the profiles and the significance of the drop outs from the different groups.

Practitioner attitudes

Further research is needed into practitioner attitude and response to technological interventions, with emphasis on understanding the source of these attitudes and the implications of these. For example, lack of technological skill and confidence may require one response, whereas concerns based on perceived client need require very different consideration. It must not be assumed that unease over technology is either resistance or protectionism: if technology is to

be used ethically both practitioners and clients need to be at the core, and research needs to address this.

Mallen *et al.* (2005) conclude that 'thus far research has demonstrated that according to clients self reports they perceive forms of online counselling as satisfactory and useful. It appears that professionals are less likely to accept new modes of treatment … because they possess knowledge and training in the effectiveness of traditional treatments' (835). They continue 'research should investigate the possible disparity between clients' desire for and acceptance of online counseling and professionals' lack of acceptance of online counseling' (836). Whilst there is evidence to support both aspects of this view, more needs to be done to access the views and experiences of a larger population.

Training

Clearly training needs to reflect accurately the needs and demands of the job. It is therefore crucial to study whether there is a correlation between skills and knowledge required, and the content of training being offered. This applies to a range of trainings: clinical psychology, social work, counselling, psychotherapy, medicine and psychiatry, and mental health nursing in particular.

The therapeutic relationship

A crucial area is whether or not online working enhances or damages the therapeutic relationship (Wootton, 1996) and this deserves further enquiry. A related question is whether the therapeutic relationship created in online work is different to that formed in face-to-face interaction and if, therapeutically, this matters.

Benefit and harm

Mallen *et al.* (2005) suggest that areas for further research would include exploring who might most benefit from online interventions, and who would most likely to be harmed. An important area for further study is whether online service users are those who would normally avoid face-to-face treatments, and are underserved populations — for example those with physical disabilities, prisoners and young men.

Methodology

As stated previously some have argued (Lago, 1996) that technologically based services may require a different theoretical basis, but they may also need a different methodological approach. Another potential area for research is to consider whether approaches traditionally used to assess non-online methods (for example those to measure therapeutic alliance) can reasonably and effectively be applied to online work. Methodologically care has also to be taken to rigorously and transparently avoid the 'quick and dirty' concern that some practitioners anecdotally express regarding some research, one aspect of their anxiety that motivation may be financial and political rather than clinical.

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The Digital Inclusion Team works on the use of technology either directly or indirectly to improve the lives and life chances of disadvantaged people in England and the places in which they live.