Briefing paper

Web-based systems to provide psycho-education and support around mental health issues: *The Safety Net* - a potential open access development platform.

1. Introduction

The purpose of this briefing paper is to introduce the "Safety Net" a web-based programme funded by the Professional Footballers Association to provide self-help guidance and mental health awareness and support, to young people engaged in training to be professional footballers within the Academy Football programme. The website has now been operating for two years and has been well received by academies and league clubs where it has been introduced.

The developers behind the Safety Net, are all experienced practitioners within the areas of graphics and web design, professional sports coaching, sports psychology, education, clinical and health psychology, and mental health. Although the Safety Net was designed specifically to meet the requirements of footballers and PFA, the developers are aware that it could have wider potential applications for promoting mental health and well-being for both adults, and children and young people.

Within this paper, we describe the development of the Safety Net and its implementation within professional football. We then go on to outline its potential contribution to promoting mental health and wellbeing, together with the provision of self-help information and signposting to appropriate mental health services. We outline how the Safety Net might be adapted for use in adult services, and particularly its use by Psychological Wellbeing Practitioners to enhance Step 2 interventions and also to provide greater access to local IAPT services and promoting self-referral. In doing so, we will evaluate the evidence (see Appendix 1) to support the adoption of web-based resources and self-help materials in providing advice and initial support to people with mental health problems as part of a comprehensive "stepped care model" of mental health service delivery.

We also describe how it could easily be adapted as a front-end portal for local CAMHS services and a means to provide psycho-education and support materials. The widespread availability of such a resource, we would argue, might help the 60% of adults or the 70% children and young people with common mental health problems, which currently do not come forward for assessment or treatment. We would argue that early intervention for mental health problems, especially for children and young people, should result in significant economic savings over the longer-term (see Appendix 1). This would be in line with the recent CAMHS Taskforce Report (2015), which stressed the importance of social media and e-technology in raising awareness of mental health issues in C&YP and encouraging them to seek assistance from appropriate services. Such an approach would also seek to promote wellbeing, reduce stigma, and enhance mental health literacy for C & YP and their parents/carers.

We go on to make some suggestions as to how local services and commissioners might help promote and develop the Safety Net concept to benefit public mental health within the locality. We also believe that there may also be national opportunities, which we will pursue with the relevant government departments and national charities. We also believe that the implementation of the Safety Net is consistent with recent developments in mental health policy and its potential is supported by the existing evidence base. We have included, therefore, a targeted review of the relevant policy background for both adult and C&YP mental health services, and an appraisal of the research evidence concerning self-help and e-therapy applications.

2. Introduction to the Safety Net

It has recently been recognized that professional footballers frequently struggle with mental health issues and experience difficulties accessing appropriate help and support. This can lead to substance abuse and addiction, family and relationship problems, depression and even suicide. For example, Gouttebarge et al. (2015) have recently reported in the Journal of Occupational Medicine, that within professional footballers, 26% will suffer from depression/anxiety and that this rises to 39% amongst those that have retired from the sport. http://gu.com/p/4d36h/sbl. These percentages are higher than would be expected in the general population. Echoing concern about these figures, FIFA has announced a new research project "Mental Health and Sport" which aims to combat stigma and facilitate treatment for professionals. Similarly, the mental health charity Mind has published a report on the mental health of elite athletes (Mind, 2014). Indeed, the previous deputy Prime Minister from the Coalition Government t launched a national initiative to harness the benefits of sport and exercise on mental health and wellbeing (https://www.gov.uk/government/news/deputy-prime-minister-launches-mental-health-in-sport-initiative).

Responding to these concerns and pressures, the Professional Footballers Association (PFA) commissioned from Aim-For[1] a web-based support system "The Safety Net", together with access to counseling. The platform provides an easily accessible menu of mental health topics and sources of advice and is available to member players and also to aspiring footballers who are members of the national network of Football Academies (With over 4,000 14-21 year olds belonging to 72 academies). The platform is now available to all young professional footballers in the Academy system, and a pilot study supported by the PFA to evaluate the platform and associated materials is planned for the autumn of 2015.

A particular feature of the design of the Safety Net has been the attention paid to making it accessible and attractive to young people and players who might otherwise be put off by psychological jargon or perceived weaknesses Wellard (2002) Wong, Y. J. et al, (2010). Steinfeldt Jesse A. et al (2011) such as mental health issues. The language adopted has

[1] *Aim-For is a limited company founded in 2010 by Lee Richardson MBPsS Performance Psychologist and consists of partner Nick Richardson(BSc) IT specialist and former school Head of Department and teacher, together with clinical psychology consultants Peter Leakey and Professor Graham Turpin. In 2012 AIM FOR designed and published the twin e-platforms of the Four Pillars (Achievement & well Being) and The Safety Net (Mental Health Psychoeducation & support).*

been chosen to be easily understood and to avoid jargon or stigmatizing terms. Nearly all the information is presented through a short (i.e. under 5 minutes) and engaging video-cartoon format with attractive animation. The videos/ animations are intended to be easy to watch, and to appeal to younger people. They are designed to raise awareness of the issue, provide information and coping strategies and to help identify when to seek professional help. The Safety Net Platform is being adapted to provide a language translation feature for most languages.

Concepts such as depression or anxiety are first introduced in a concise format, with the offer of additional extended explanations being available together with 24/7 online or telephone counseling support. There are additional links to resources such as self-assessment measures of depression, anxiety and wellbeing, and also resources for developing coping skills such as slow breathing, relaxation and confidence building. There are also links to award winning leaflets, information and useful telephone contact numbers. The easy access to the telephone and email link is intended to lower the threshold for help seeking, which is poor in young people. (70% of young people with a mental health problem do not seek help).

The videos involve a combined visual and audio presentation of the script to reduce cognitive effort. They are briskly paced to keep attention and avoid jargon or complex words where possible. The voice over adopts a matter of fact, non-sensational or patronising style. The use of graphics or simple animations is combined with the written words to enhance understanding and interest. We believe that the particular format adopted has led to its successful uptake by both players and young people.

We have demonstrated the Safety-Net to a range of professionals directly outside of professional sport and football, and have received encouraging feedback that the web-based platform might be easily adapted to enable a wider adoption within both schools and mental health services. The purpose of this briefing paper, therefore, is to review the use of the Safety-Net, and to examine how it might benefit the public (i.e. both children and young people, and adults) at large by offering an easily accessible web-resource around mental health issues so as to enhance general levels of mental health literacy within the community, to encourage people with mental health problems to seek help (both from primary and secondary care) and provide psycho-education and self-help support for those clients awaiting psychological treatment on GP waiting lists.

The existing sports/football theme might also offer a more acceptable and attractive route into schools and colleges around dealing with mental health issues through its relevance to sport in schools and professional sports people acting as case studies and role models. Indeed, we have already discussed with the English Youth Sport Trust and Sport for Schools, the possible adoption of the Safety Net and its sports coaching sister website: The Four Pillars. It has been agreed that AIM–FOR will be carrying out a pilot of the AIM programme which includes the Safety Net in a selection of Secondary Schools due to commence in Autumn-Winter 2015.

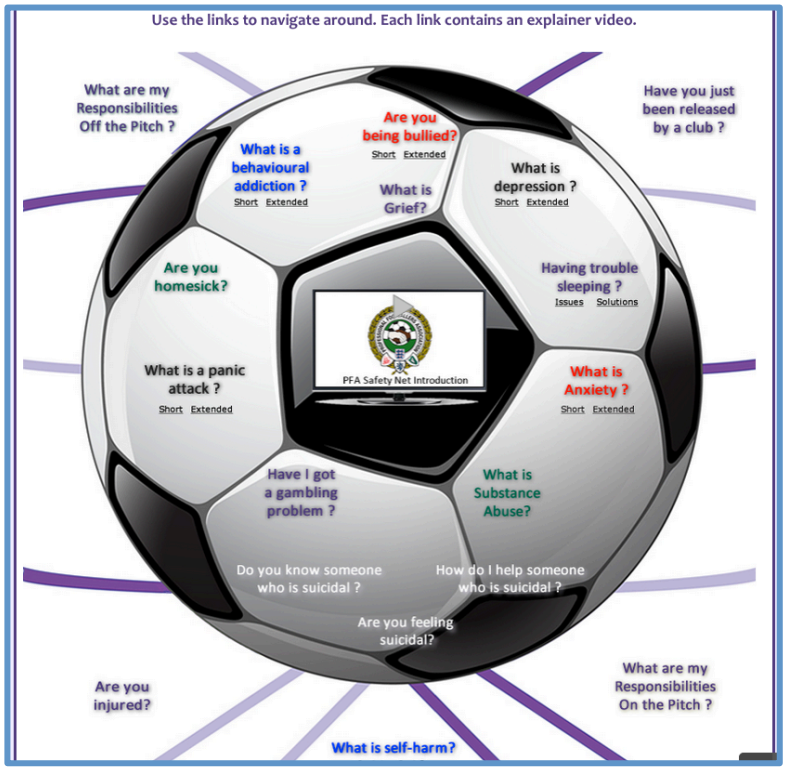
3. Brief description of the Safety Net and The Four Pillars

The original web platform was developed in 2009 by Lee Richardson of Aim For as a means of introducing psychology to football coaching both for professional players and also trainee footballers attending Football Academies. Richardson was uniquely placed having been a professional player, coach and manager, but also having studied psychology and gained a Masters in Sports Psychology. Whereas the discipline of Sports Psychology has been widely adopted in athletics and other Olympic sports, its introduction into coaching within professional football has been slow. Indeed, Pain and Harwood (2007) identified six barriers to its adoption and these included negative perceptions of psychology within the football world, little contact between professional coaches and sports psychologists, practical constraints (time and resources), and lack of perceived value. The web-based platform was designed so as to introduce players and coaches to a sports psychology based system of performance enhancement and improved well-being. The Four Pillars adopts a classic sports psychology model of focusing on relationships, motivation, cognitions and emotion in order to enhance both personal/social development and skill and performance. Two other sports psychologists, Dr. Matt Slater and Dr. Martin Turner (University of Staffordshire), also contributed to the development of the Four Pillars. As a coaching tool for professional football, it was been adopted by the PFA and rolled out to the Football Academies, including West Ham United Academy in the Premier and is about to be adopted by other clubs. Also a cricket based version, of The Four Pillars, is also being used by Lancashire County Cricket club. The Psychosocial Performance and Well-being Platform is used by the whole club, including the first team and academy.

Although the Four Pillars relevance directly to mental health may not be seen clearly, it does address a whole series of psychosocial and cognitive strategies for enhancing relationships, motivation and performance which all contribute to a positive sense of well-being. It is possible that it could provide the basis for an equivalent web-based platform for enhancing well-being along the lines of positive psychology and what is regarded as emotional intelligence. Such a web-based resource could from a public health perspective serve to enhance mental health promotion and well-being within communities.

The practical relevance of psychology to football was also realized by a productive partnership (from 2003 onwards) between Richardson whilst assistant and then manager of Chesterfield FC and Peter Leakey, the then Head of Health Psychology within Derbyshire Community Health Service. As well as introducing psychology to the team's coaching, it also helped to reveal the mental health issues that some players from the club had to contend with both on and off the pitch. At the same time, there was growing recognition and concern about how professional clubs dealt with and supported players experiencing mental health difficulties. This gave rise to the parallel development of the Safety Net in order to provide web-based information about relevant mental health issues, animated explanations surrounding common mental health problems, questionnaires, downloadable self-help booklets, and access to the PFA's network of counselors via e-mail or a 24 hour telephone helpline. Topics considered particularly relevant for footballers were: addiction and substance abuse, anxiety, bullying, depression, gambling, grief, home sickness, panic, self-harm and suicide, sleep and also advice on well-being, mood, relaxation, overcoming stress etc. These topics are presented using an attractively designed menu (i.e. a football with each of the topics making up the ball) and then

explained either with a brief (fewer than 2 mins) animated cartoon or as an extended version ([under 5 mins.]). It needs to be emphasized that throughout the website, the importance of encouraging help-seeking via contacting the PFA counseling network is stressed.



4. Relevance of the Safety Net to provision of mental health services

A role for the Safety Net?

We believe that the Safety Net in its present form could be adapted to form the basis of an initial portal for primary care mental health services within a local community. The portal would provide a number of functions and these might include:

i. Providing basic information about common mental health problems in an informative and accessible manner. We believe that the cartoon animations underlying the Safety Net provide information in a more attractive and accessible format than existing portals such as the NHS Choices Mood Zone or the BBC. These tend to use *either* audio clips or just text, which we believe are less interesting than the animated format developed for the Safety Net. The option of introductory clips, followed by more extensive explanations, again provides a means for tailoring the information to the preferences and need of the user.

The current Safety Net also has links to 24 hour counseling support either via e-mail or the telephone. Local services would need to decide how and whether they would wish to have a similar level of functionality. For example, for adult services, the portal could offer a self-referral pathway into IAPT services and the opportunity to receive an assessment by PWP worker in the near future. As with other similar portals it would also signpost 24 hour emergency or crisis helplines offered by relevant mental health charities.

The format of the Safety Net could be tailored to meet local requirements and also to target the age of potential users (i.e. different formats for children, young adults, adults and older adults) and whether they themselves are experiencing mental health difficulties or know of someone or caring for someone with problems. Specific local services could be sign posted.

The use of the Safety Net in this way would help to improve the levels of mental health literacy within a community and by doing so encourage greater rates of help-seeking and self-referral to appropriate services.

ii. Providing self-help guidance and more detailed information booklets. The self-help materials available could be used in a number ways.

For those individuals wishing to work on their mental health conditions without professional involvement, the limited self-help strategies might provide a useful alternative. The portal could also link to other self-help websites or the national Reading Agency *Books on Prescription* scheme for Common Mental Disorders available in most English libraries. Confidentiality and use of the safety net would be an important issue to address for these users.

Self-help could also be recommended by GPs and IAPT services whilst patients are waiting for either assessments or treatments.

Finally, self-help and psycho-educational materials might also be targeted at relatives and carers both to help them understand various mental health conditions but also to encourage their relative to come forward and seek help, if their problems persist.

iii. The portal could also be expanded to include more positive mental health promotion information and messages. This would require the adaptation of The Four Pillars to encompass mental health promotion strategies, and the possibility of promoting emotional intelligence and positive psychology interventions.

It is also important to recognize what the Safety Net would not provide. In its current form it educates, sign posts and provides aspects of self-help. It does not specifically provide e-therapy or computerized therapy such as Beating the Blues or Fear Fighter. The development of more intensive e-therapies is a possible area for future development. Similarly, we would not advocate specific counseling support, as in the PFA version, to be provided within NHS versions, since services ought to have their own systems and staff in place to support the Safety Net.

5. Possible bespoke adaptations

The website could be adapted to other users by:

1) Expanding the range of topics covered.

2) Making the style of presentation and language appropriate for the intended audience, currently it targets only young male footballers.

3) Adding further links to relevant coping skills, sources of information and treatment options.

4) Linking to an organisation's own Counselling/Therapy or support services or

The web page could also be adapted to act as a portal to other services, such as CAMHS, IAPT or Public Health services for example. There would of course be close involvement of the users of this product in designing it to fit with local services, and to ensure that the educational content was congruent with local attitudes and professional practice.

6. Conclusions and future action points

1. We believe that AIM-FOR and the Safety Net provide an attractive and accessible mental health and well-being web portal designed originally with young people in mind, particularly those attending Football Academies sponsored by the PFA. The PFA have rolled out its implementation nationally and is currently evaluating its effectiveness. In the meantime AIM-FOR wishes to develop the web portal further with two target audiences.

2. The first obvious audience is children and young people. As recently recommended in the Task Force Report on C&YP Mental Health, e-mental health applications may have an important role in raising wellbeing awareness in C&YP, providing e-based psycho-education and self-help, and offering the potential for e-therapy. As reviewed in Appendix 1, these developments are at an early stage of development and lack a reliable evidence base. Given that the Safety Net has been designed with young people in mind, albeit young males, we believe that it would relatively easy to redesign the website so that it could provide an accessible portal to CAMHS.

3. The second would be as a portal to adult IAPT services providing psycho-education, raising mental health awareness, promoting local services, and hopefully being instrumental in increasing local access to services through both professional and self-referral. This would involve investment to support the overall presentation of the website making it appropriate for adults as opposed to young people. The policy background and evidence-base to support such a development is outlined in Appendix 1.

4. We have written this briefing paper to be used for several different purposes and audiences. These include:

    - Approaching national bodies (e.g. NHS England, MindEd, IAPT and C&YP IAPT) to ascertain whether they would be interested in facilitating the development of AIM-FOR.

    - Approaching national children's charities (e.g. Young Minds, Mental Health Foundation) to seek support and investment. In particular, we are aware that there has been limited direct user participation in the design of the site. We would be particularly interested in co-production with service users to enhance the site's accessibility and attractiveness. This would also apply to charities focused on adults.

    - Approaching local organisations (e.g. Health and Well-being Boards, Public Health England, Clinical Commissioning Groups) and services (e.g. CAMHS, IAPT, MIND). We would be interested in whether the portal could be adapted to local needs and personalized for a particular service or locality.

    - Approaching regional networks (e.g. Academic Health Science Networks, MindTech Healthcare Technology Co-operative) to explore possible avenues for collaboration and support.

    - Approaching commercial organisations already involved in implementing e-mental health strategies and self-help and psycho-education initiatives.

If you are interested in exploring AIM-FOR and the Safety net further, please contact Lee Richardson by e-mail on lee@aim-for.com or by phone on Mob:07919053662.

We would be happy to meet and to demonstrate the benefits of the Safety Net for people with mental health problems and as a means of raising mental health awareness in the local community.

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Deputy Prime Minister launches mental health in sport initiative (2015)

https://www.gov.uk/government/news/deputy-prime-minister-launches-mental-health-in-sport-initiative

Appendix 1

1. Policy background for adults

The Mental Health Treatment Gap and its consequences

There is a major discrepancy between the number of people in receipt of interventions for common mental health problems and their prevalence within the population. The World Health Organisation refers to this as the Mental Health Treatment Gap (WHO, 2013) and it varies across continents, countries and communities. Recently within the UK, there has been a concerted effort at tackling this gap, and in particular increasing access to psychological treatments for anxiety and depression available from primary care. Economists such as Lord Layard have argued (The Depression Report: London School of Economics, 2006) that the failure to effectively treat common mental health problems leads to an increased economic burden for the country (GBP 12 billion p.a.) and the exchequer (GBP 7 billion p.a.), due to people with mental health problems being unable to find or sustain employment, increased benefits and disability payments, increased burden on care and health services, and the overall negative impact on the person and their family's quality of life. The economic case for early intervention within mental health services for children and young people (C&YP) is even more compelling. Knapp et al. (2011) have estimated that the failure to provide adequate C&YP mental health services results in costs accruing to the exchequer due to unemployment, the criminal justice system, etc. using conduct disorder as an example, they estimate that the cost of failing to effectively treat the condition costs GDP100 m to public services.

Resourcing and the treatment gap?

A major determinant of the MHTG is the availability of resources to provide adequate and effective treatments. Over the last decade, successive governments have attempted to increase access to effective treatments by training more relevant health professionals. In the case of common mental health disorders, this has resulted in the Improving Access to Psychological Therapies programme in England that has seen 6,000 additional psychological therapists trained since 2007 (DH: Talking Therapies, Four year Plan, 2011). More recently, we have seen major investments in C&YP IAPT and greater availability of training for CAMHS therapists and managers. Currently, C&YP IAPT has been rolled out across 60% of CAMH services throughout England (http://www.cypiapt.org). The common features of IAPT services are the provision of NICE-approved psychological therapies, a workforce comprising appropriately trained and supervised therapists, and the collection of session-by-session clinical outcome measures. Indeed, for adult services it has been possible to monitor through the NHS Health and Social Care Information Centre (http://www.hscic.gov.uk) the numbers of patients accessing services and entering therapy, together with their clinical outcomes in the form of recovery rates. IAPT services through the commissioning process should be aiming for 15% of local population prevalence for common mental health problems entering therapy.

It is notable that this only constitutes 15% of prevalence, which would indicate a MHTG of 85%. Why are commissioners prepared to accept what would appear on the face of it very limited access to treatment for common mental health problems? Is this a further indication

of the under-investment in mental health services? To answer this requires a better understanding of what constitutes the MHTG? Availability of treatments and resources are only one determinant of the gap. For people to access treatment, they 1) need initially to seek treatment or help, and 2) their mental health problem needs to be accurately detected or diagnosed. For depression, it is likely that the majority of people experiencing depression (60%) do not actually seek treatment. Of the remaining 40%, perhaps just over half of these will be diagnosed with depression by their GP. Although detection rates for depression are improving with better GP training in mental health, detection still remains problematic especially in some cultures (e.g. South East Asian women). Given these statistics, IAPT targets of 15% or even a hypothetical target of 30% become more understandable. Moreover, some GPs require further training about the efficacy of psychological therapies and those people most likely to benefit (e.g. older people).

Other barriers to access?

Why do the majority of people experiencing depression fail to seek treatment? There are numerous reasons, perhaps many of them overlapping. For example, people or their relatives may not be aware that they have a treatable mental health condition. If they, do they might be concerned about the stigma associated with it and possible adverse consequences such as losing a job, shaming a family, etc. They might also have pessimistic and negative perceptions of treatment including adverse side-effects and long waiting lists. There might be cultural barriers and people may seek help from religious leaders or other forms of support (e.g. traditional healers) within the community. The service might also not be accessible either due to geographical location, opening times, or affordability (e.g. time off work, travel expenses).

What could we do to alleviate some of the factors identified above? Clearly, recent campaigns to de-stigmatise mental health difficulties and general health promotion campaigns to enhance mental health literacy and understanding are all worthwhile. For some individuals, however, they might have a desire to manage their mental health issues without professional help or intervention. This approach has the lowest risk when it comes to identification and stigma. It also does not mean that no intervention is available. It has been argued that self-help interventions may provide a useful means to manage some mental health problems where the client is unwilling to come forward or risks being .identified. Such approaches have recently been offered to veterans and other service personnel afraid of stigmatization and discrimination. They might also facilitate help-seeking but so far there is only limited evidence for this in adults (Musiat and Tarrier, 2014).

2. Mental health services for children and young people

The last decade has seen a growing concern about the adequacy of mental health services for children and young people as indicated by growing waiting times for CAMH services, inappropriate inpatient placements, increasing levels of self-harm and overall falling levels of investment in C&YP mental health. Given the previously cited economic impact of failure to adequately treat childhood mental health problems, and a growing public dissatisfaction with the adequacy of many services, it is not surprising that C&YP mental health problems have become a policy priority for the government.

In the last decade, a series of important policy developments and reviews have taken place. A convenient starting point is 2004, and the publication of a ten year National Service Framework, which identified specified standards for mental health and psychological wellbeing for C&YP (Department of Health, 2004). This work continued under the new Coalition Government and was subsumed under the new mental health strategy No Health without Mental Health (Department of Health, 2011), which deliberately addressed mental health policy across the age range. In 2012, the C&YP's Health Outcomes Forum produced an overarching report, together with a mental health subgroup. Its essence was to identify health outcomes that would matter most to children and to place C&YP and their families at the heart of the strategy. They identified six high level objectives:

- More children and young people will have good mental health
- More children and young people with mental health problems will recover
- More children and young people with mental health problems will have good physical health and more children and young people with physical ill-health will have better mental health
- More children and young people will have a positive experience of care and support
- Fewer children and young people will suffer avoidable harm
- Fewer children and young people and families will experience stigma and discrimination

A further review of children's services was commissioned by the Chief Medical Officer and published in December 2012, with a chapter on mental health (Murphy and Fonagy, 2012) and some key recommendations made which included:

- Investment in C&YP mental health services should be proportionate to the associated health burden
- Government policy should focus on inequality and promote mental health and ill health prevention
- Increasing support for parents and the enhancement of parenting skills
- The important role of schools in promoting psychological wellbeing and resilience
- The need to promote evidence-based interventions and undertake routine measurement of clinical outcomes
- The need to address shortfalls in the supply of the CAMHS workforce

A little while afterwards, the Joint Commissioning Panel for Mental Health published its commissioning guidance for CAMHS services (2013) and included 10 key messages for commissioners of services, which included:

- The moral and economic case for investment in CAMHS services. Despite recent increased investment, shortfalls in service capacity remain
- Parity of esteem between physical and mental health
- Expanding access to C&YP's IAPT
- The impact of C&YP disorders on adults
- The importance of integrated, multi-agency working and commissioning

- The value of liaising with schools and local authorities
- Involvement of C&YP and families and carers in the commissioning process.

The CMO review also prompted a Parliamentary Health Select Committee enquiry into CAMHS services in 2014. This highlighted problems with availability of beds and appropriate inpatient care for C&YP, cuts in early intervention services, and long waiting times for community CAMHS. In response, the government announced a Taskforce to look into ways by which CAMHS might be better organised. The Taskforce report has recently been published (Department of Health, 2015) and has highlighted amongst other things the importance of social media and e-technology in raising awareness of mental health issues in C&YP and encouraging them to seek assistance from appropriate services. Finally, C&YP IAPT have published recent guidance on CAMHS service standards (http://www.england.nhs.uk/wp-content/uploads/2014/12/delvr-with-delvrng-well.pdf)

3. Potential solutions and the supporting evidence base

Adult IAPT services and stepped care service delivery models

The introduction of IAPT services within primary care in the last decade has seen a large improvement in the overall numbers of patients entering therapy and a dramatic decrease in waiting times compared to services prior to IAPT. This has been achieved by increasing the numbers of trained therapists but also by the introduction of a stepped care service model. Patients are offered either low intensity interventions which are typically shorter and delivered in fewer sessions, or high intensity interventions such as Cognitive behavior Therapy delivered according to NICE clinical guidelines. Low intensity interventions typically include psycho-education, self-help and bibliotherapy, computerized CBT, behavioural activation and telephone counseling and support. These are usually delivered by psychological well-being practitioners (PWP) who act as advisers and coaches within IAPT services and are frequently supervised by more experienced therapists. High intensity therapies are delivered by fully trained and accredited psychological therapists and counselors. Patients can access these directly in some cases or are “stepped up” having initially been seen by a PWP offering low intensity interventions.

Stepped care services have been shown to be effective and provide greater access and patient flows through the care pathway (Firth et al., 2015), although their superiority over purely high intensity therapy services has yet to be proved (van Straten et al., 2014). It is important that effective low intensity therapies such as guided self-help and computerized therapy are readily available within the service. Recent developments have seen the promotion of bibliotherapy and self-help through the Reading Agency Books on Prescription scheme for Common Mental Health Conditions (http://readingagency.org.uk/adults/quick-guides/reading-well), which saw the borrowing of over 250,000 titles nationally within England from public libraries in its first year of operation in 2013/14.

There is also continued interest in the provision of web-based information and therapy at the step two level within the stepped care model. In addition to the originally NICE endorsed “Fear fighter” and “Beating the blues” there has been a proliferation of both CD-ROM and web-based programs within the UK and abroad offering therapy of varying degrees of sophistication, professional support, demonstrated effectiveness and

accessibility and cost. Recent research supports its effectiveness for depression (Richards and Richardson, 2012; Foroushani et al., 2011) but there are significant barriers to its uptake and whether patients complete a full course of treatment (Waller and Gilbody, 2009). Moreover, doubts about its longer term effectiveness and ability to improve functioning in depressed patients have recently arisen in meta-analyses of long-term outcomes (Christensen and Mackinnon, 2013). Nevertheless, a comprehensive review of e-mental health by Musiat and Tarrier (2014) was generally supportive of cost effectiveness, patient satisfaction and acceptability but identified the need for further research. In particular, the general perception of computerised therapy (Musiat et al., 2014) by the general public and preferences by patients for therapist contact (Hanson et al., in press) require serious consideration if e-therapy platforms are to be widely promoted.

Finally, one distinctive feature of many IAPT services is the use of self-referral, in addition to the usual GP referral route. This has enabled IAPT services to be promoted through non-health settings such as libraries, faith groups etc. and it is hoped that this is a means of de-stigmatising the service and also overcoming some of the barriers to referral for particular under-represented groups. However, self-referral in to IAPT services places a significant burden on services to market and promote their service within the local community. One means of doing this is via web-portals that provide information on mental health and also local contact details for services. Such websites exist nationally and include NHS Choices, as well as national charities (e.g. Mind) and local primary care and mental health NHS trusts and services.

Children and young peoples' mental health services

The recent Taskforce Report (2015) proposes a radical change in how CAMHS are organized emphasizing the need for more effective early intervention services, greater integration across services, and ensuring that they are more C&YP focused and that parents and carers have greater opportunities for involvement with services. Greater investment in CAMHS has also been recently announced within the last budget so as to help implement the Taskforce's recommendations.

These proposals are in addition to the reform of CAMHS that has been taking place due to the introduction of C&YP IAPT. Like the Adult IAPT programme, C&YP seeks to enhance the training of existing practitioners in evidence-based psychological therapies, ensure good quality supervision and leadership of services, and obtain routine published clinical outcomes. They have recently published (http://www.cypiapt.org) detailed guidance around commissioning CAMHS services, a National Curriculum for training staff, working collaboratively with C&YP and families, and have set up a C&YP facing portal (Myapt) and an educational portal (MindEd). They also worked with GIFT at the Department of Health to organise a series of focus groups to review how C&YP and their parents valued their involvement in CAMHS services http://www.cypiapt.org/sitefiles/ Final report of GIFT parents' interim consultation.pdf). Their report, which was published in April 2014, identified the importance of good effective communication and information around services from the start, difficulties around access and stigma, and ways of enhancing parental and carer participation in services.

One aspect of developments surrounding CAMHS, which is pertinent to this briefing document, is the growing interest in CBT, self-help and e-therapy approaches for C&YP. Generally there is good empirical support for the effectiveness of behaviour therapy and CBT in alleviating the symptoms of anxiety in children. A recent meta-analytic review of anxiety in children and adolescents by Reynolds, Wilson, Austin and Hooper (2012) examined 55 studies and endorsed the effectiveness of CBT for a variety of anxiety disorders. There was some evidence to suggest that treatments were even more effective if targeted at specific anxiety problems, delivered individually rather than in a group, to older (adolescents as opposed to children) and for longer sessions. In 2013, a Cochrane Review of CBT for anxiety disorders in C&YP was published (James et al., 2013) which looked at 41 studies. Again the review attested to the effectiveness of CBT compared to wait list controls. It is worth noting that there were no differences when CBT was compared to an active control such as the use of self-help books.

Creswell, Waite and Cooper (2014) published a narrative review of the assessment and management of anxiety in C&YP. Although they further endorse the efficacy of CBT approaches, they interestingly note the growing acceptance and use of low intensity interventions in this area. As discussed above, low intensity interventions are psychosocial treatments, which might be limited both in duration and number of sessions, and delivered through a variety of formats: group educational, individual face-to-face, telephone and internet. Two particular approaches are identified: 1) bibliotherapy usually involving *both* children and parents delivered in a group format and 2) self-help but supported through new web-based technologies.

There have been several recent reviews of the efficacy of bibliotherapy and self-help. Elgar and McGrath (2008) extensively review self-help interventions with children including bibliotherapy, internet-based applications and the use of self-help groups. They distinguish between inspirational bibliotherapy, which tends to focus around self-improvement, versus manualised therapeutic approaches. The former tends to have little in the way of an evidence-base, although many titles have been promoted by psychologists. They conclude that instructional bibliotherapy based on therapeutic manuals has a reasonable evidence base around children's emotional disorders. Similarly, they conclude that instructional manuals targeting better parenting for parents are also supported by the evidence. They also go on to evaluate internet based programmes and their future potential for services

Several reviews focus on the contemporary self-help literature for C&YP and do not make an explicit attempt to distinguish between bibliotherapy and self-help programmes delivered either by the internet or CD Rom. Turner and Krebs (2012) provide an insightful review of low intensity interventions for C&YP, which again includes bibliotherapy and more technologically sophisticated applications. Ahmead and Bower (2008) meta-analytically reviewed self-help technologies (over half involved bibliotherapy) for emotional problems in adolescents. Unfortunately the studies were relatively few and many were small and of a poor methodological quality. Despite some positive findings, their overall conclusion was that the routine use of internet-based interventions for adolescents was not presently substantiated by the evidence. A similar review by Rickwood and Bradford (2012) but for mild anxiety disorders in young people came to similar conclusions as regards the relative scarcity of research evidence and poor methods. They focused on self-help internet-based programmes which only required the minimum of additional therapeutic support.

There have been several recent reviews that have just focused on e-health applications. The first was commissioned by MindEd to examine e-Therapies for C&YP (https://www.minded.org.uk/pluginfile.php/1287/course/section/579/e-Therapies%20link1-

%20leaflet.pdf) and has just been published (Pennant et al., in press). Moderate effects were obtained for anxiety and depression but only in young people (12-25 years) whereas the impact CBT for children (5-12 years) was more uncertain. The authors discuss the need for further innovation and development work around these programmes. Donovan, Spence and March (2012) have also reviewed new technologies in the delivery of CBT for C&YP. In their narrative review they are more enthusiastic about the contribution that these technologies can make but mainly with respect to therapist guided internet-based self-help.

The use online resources have also been recommended as a means of enhancing mental health awareness in C&YP and facilitating help seeking. Kauer, Mangan and Sanci (2014) systematically reviewed the literature in this area. Despite the widespread availability of online information resources for C&YP, they identified only 18 studies. They concluded that overall, none of these studies provided evidence that online resources actually promoted help seeking. Nonetheless, the studies did demonstrate that young people regularly used these services, would recommend them to their friends and displayed modest levels of satisfaction with the service they received. A recently published RCT (Taylor-Rodgers, et al. 2014) using university students (18 – 25 years), has reported promising improvements in help seeking attitudes and intentions, and mental health literacy as a result of regular exposure to a tailored mental health psycho-education programme.

In summary, the recent reviews above are largely consistent with NICE guidance and support the use of CBT-derived bibliotherapy with C&YP for anxiety disorders and depression. Effectiveness is usually enhanced if the self-help is guided by a mental health professional either individually or within a group setting. For C&YP, the inclusion of parents in the delivery of self-help maybe an important practical aspect of delivery. Recently, there has been a proliferation of internet and CD Rom based programmes offering information, preventative programmes and therapeutic interventions. Despite their popularity, further research and development is required to firmly establish the effectiveness of e-based interventions. Some C&YP demonstrate a preference for using self-help interventions in an unguided or independent mode, as an alternative to conventional services.

Finally, although not focused specifically on CBT treatment of emotional disorders, there is a substantial body of research looking at CBT-based preventative programmes targeting depression and/or anxiety in C&YP, and usually delivered within schools. This approach has been reviewed by Stallard (2013) who concludes that although there are a number of small scale studies that have demonstrated positive results in the short-term, evidence to support effectiveness in the longer term or in large scale implementation projects has been disappointing, leading him to question whether schools currently have the right ethos for mental health prevention work? An associated area is counselling in schools that has become a component of C&YP IAPT (http://www.bacp.co.uk/admin/structure/files/pdf/11791_sbc_may2013.pdf).

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