WHITE PAPER

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MAKING SPACE FOR HEALTHY MINDS

Key dos and don'ts in commissioning an online Behavioural Health and Mental Wellness Solution for Higher Education

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Table of Contents.

1. Introduction.

Academic pressures, stress, transition, isolation and financial worries among other factors puts higher education students into one of the most vulnerable groups for the onset of mental health difficulties. Anxiety disorders have been reported to affect 25-30% of third level students (Dooley & Fitzgerald, 2012). It is not unusual to see high prevalence of distress in this population. Many university mental health services in the UK and US have seen an increase in user numbers and problem severity (Mowbray et al., 2006; Rana, Smith, & Wlaking, 1999; Royal College of Psychiatrists, 2011).

Computer-based cognitive behavioural interventions have been shown to be an efficient and innovative solution and have been recommended by NICE (2009) as a low-intensity intervention, especially for the high prevalence mental health presentations such as anxiety and depressive disorders (Andrews, Cuijpers, Craske, McEvoy, & Titov, 2010; Richards & Richardson, 2012). With a growing market of possible choices how can higher education institutions make informed decisions regarding the adoption of the most appropriate online solution that can meet the parameters of clinical effectiveness and cost-efficiency? The present paper aims to support Higher Education Institutions in selecting online behavioural health and mental health wellness solutions by highlighting features that need to be given consideration.

2. Student services.

The mission of Student Services at places of Higher Education including health services, counselling services, career services and all of the various other student provided social, cultural and academic services is to support the individual in the realisation of their academic potential and success. Mental Health services see upwards of 6% and in some cases more of their student population with issues that are high in prevalence including stress, depression, anxiety, and relationships.

The burden of morbidity of common mental health issues such as anxiety and depression has been well documented (Richards, 2011). Depression alone accounts for 7% of the burden of disease in the UK, which is the largest impact for a single condition (World Health Organization, 2004).

The human, social and economic impact on individuals and society are significant, resulting in low levels of well-being, physical illness and overall poor quality of life, increased need for health and social services, loss in productivity, unemployment and dependence on social welfare to name just a few examples. For students such a scenario can be devastating and with growing pressures on services including stigma associated with accessing mental health treatment students can find themselves in difficulty. However, such a scenario can mean academic failure and dropping out from their studies. Furthermore, any such underachievement or failure can have long-term consequences on self-esteem and progress in future life (Royal College of Psychiatrists, 2011).

Solutions are needed and innovation required to meet the growing demands placed upon students so they can achieve their potential and academic success. Some services have addressed this by adopting a stepped care approach, delivering interventions at different levels of intensity based on individuals' needs. This facilitates an increase in accessibility and management of large numbers by ensuring that the intensity of intervention received matches with the individual's presentation and preferences and only escalates to a higher level of interventions (usually involving more time and resources) if the previous level of intervention has shown to be insufficient (Clark, 2011). Such a model could easily be transferred to students' services provision.

Low intensity interventions can successfully address the mental health needs of a large number of individuals by providing a sufficient level of care for the most common clinical presentations of anxiety and depression and stress.

A study by Richards and Suckling (2009) found that clients presenting with anxiety and depression who completed a low- intensity treatment of an average of 5 sessions, of which at least 3 contacts were by phone with a mental health worker/therapist, achieved a remission and recovery rate of 76% for depression and 74% for anxiety (Richards & Suckling, 2009). This seems to suggest that a large number of individuals with the most common presentations of anxiety and depression benefit from and make a full recovery within 6 months, with full return to productivity, through lower-level intensity interventions (Clark et al., 2009; D. A. Richards & Suckling, 2009).

3. Challenges in finding innovative solutions.

Face-to-face interventions have traditionally been the chosen delivery modality and, within a stepped care approach, low intensity interventions delivered and/or supported by a mental health worker have successfully increased access to services and somewhat reduced cost. Low-intensity delivery modalities may not just increase accessibility and reach a wider audience but may also be a better fit for some individuals.

Key to this model of services is that of increasing patient choice, providing timely access to services and achieving high levels of satisfaction among service users.

This highlights the importance of being able to provide a wide range of interventions to meet different needs and preferences as well as being appropriate to the level of distress present. As well as meeting a variety of needs it needs to ensure that individuals are able to access treatments when needed and not be waiting for a long time for these to be made available to them.

Not all individuals wish to engage in face-to-face counselling, and may face a number of obstacles to accessing traditional forms of counselling, which may even prevent them from seeking and accessing help at all. These individuals may therefore prefer other modalities of intervention.

4. Methods for increasing access and reach.

Self-help and bibliotherapy are two types of low-intensity interventions that have been recommended by NICE (2009) for individuals presenting with anxiety and depression. Computerised CBT interventions have also been put forward by the NICE guidelines (2009) as an appropriate form of low-intensity intervention, suitable for sub-threshold, mild or moderate symptoms of depression when monitored and supported by a trained practitioner.

Online interventions, as a low-intensity intervention, have the potential to drastically increase access to psychological therapies by removing a number of physical and psychological obstacles that can prevent individuals from accessing help.

Increasing access: Convenience.

Convenience of access is one of the recurrent main reasons given both by clients and therapists in choosing online interventions (Chester & Glass, 2006; Mallen, Vogel, & Rochlen, 2005; Young, 2005).

Online interventions are typically available remotely by simple access via a device with internet access and can be accessed 24/7. This makes them highly accessible removing any physical obstacles due to geographical isolation, physical disability or time constraints. It also facilitates accessing services promptly as needed with little or no waiting time for service users. With further developments in technology a wide range of accessing points such as PCs, tablets and mobile phones can be ustilised to further facilitate reaching users.

Increasing access: overcoming psychological obstacles/ psychological safety.

Individuals can also encounter a range of psychological obstacles to accessing face-to-face interventions in the form of stigma or blocks resulting from their clinical presentation.

For instance individuals presenting with social anxiety, agoraphobia and OCD may face significant psychological obstacles in attempting to physically make a face-to-face appointment as the situation would present them with a number of obstacles posed by their condition (e.g. contact with people, facing fear of open space or contamination).

Stigma about mental health can also be a powerful stumbling block encountered by individuals in seeking help. The literature on online interventions has found that because of the relative anonymity of the online environment individuals often experience a sense of disinhibition, which removes the obstacle of accessing services due to the stigma attached to mental health issues (Suler, 2000, 2004). Clients can also experience an increased sense of control and sensitivity to perceived judgment, therefore redressing a power differential that can be present in face-to-face counselling and giving clients a sense of psychological safety.

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These factors have shown to be particularly important to clients presenting with particular issues where these factors are central such as social anxiety and eating disorders (Simpson, Bell, Knox & Mitchell, 2005). In these cases an online intervention can represent a crucial stepping stone to accessing services they would otherwise be unable to access due to psychological barriers (Fenichel et al, 2002).

It is possible that a number of individuals who have been under-represented in services to date may be encountering obstacles on their way to engage with face-to-face or other types of low intensity interventions that have been offered to them, that online services may help overcome.

Cost is also dramatically reduced compared to face-to-face interventions as these interventions require a lower level of face-to-face time with a trained mental health professional. Richards and Suckling (2009) for instance reported recovery for individuals presenting with anxiety and depression with an average of 2.45 hours of therapist contact, some of which was phone support contact, hence allowing a therapist to provide support to multiple individuals within the same timeframe. High intensity interventions are typically based on an average of 16-20 face-to-face sessions with a highly skilled trained mental health professional.

Online interventions may therefore be a solution to the challenge of finding innovative ways to further increase access to evidence based psychological interventions. They are an additional option for suitable individuals and can help to extend reach by removing obstacles to accessing traditionally delivered services.

5. What does an online solution need to offer?

A wide range of online psychological interventions have emerged since the development and widespread availability of computer technologies. These have taken very different shapes and forms, which can make it difficult to assess their suitability to meet the criteria for a specific service. The following section aims to give an overview of the main content and platform features that may be useful to consider in the process of selecting a suitable online therapeutic programme.

6. Key features of an online behavioural health and mental wellness programme.

These are programmes with evidence-based therapeutic content delivered to users via computer technology and/or online and are self-administered by users with different degrees of personal support and monitoring provided by a therapist/mental health practitioner. The level of one-to-one support by a trained practitioner is for the most part greatly reduced, allowing clinicians to monitor and provide feedback to multiple users, therefore freeing up their time and increasing capacity.

Such programmes can therefore bring many of the benefits of delivering therapeutic interventions in an online environment already mentioned, while also significantly reducing the cost and time in providing the service. There are however a number of important factors concerning the content and platform functionalities that need to be considered in selecting a solution to meet the needs and standards required for service delivery.

6.1. Evidence based content: A first point to note is to ensure that the content delivered in online programmes is evidence-based. Cognitive behavioural therapy (CBT) is a therapeutic approach based on the principle that clients' difficulties can be understood and modified by modifying the interactions between thoughts (cognitions), behaviours and emotions. Because CBT is a very structured approach, it lends itself well to being easily delivered and self-administered. (e.g. beating the blues, fearfighter). Yet, other theoretical approaches including the use of mindfulness and positive psychology as aspects of interventions are growing in use and prevalence in psychology and therefore should be welcomed. In fact, other approaches that are showing promise from 3rd wave CBT and beyond can only complement the potential of any online intervention.

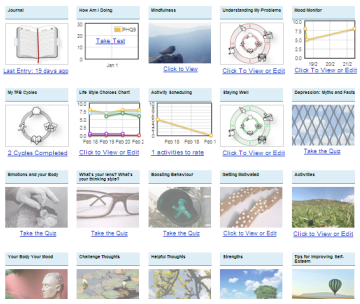
6.2. CCBT: The NICE guidelines (2009) recommend Computerised cognitive-behavioural therapy (CCBT) as an evidence-based approach that is suitable as a mode of delivery of interventions to clients presenting with mild to moderate anxiety and depression. CCBT programmes are usually delivered in 6-8 modules, each of which would typically be taken weekly, including the completion of between-sessions homework tasks. An important active component of CBT protocols are the need for clients to implement action-plans and practice techniques learnt and have a space to reflect. It is therefore important to ensure the programme contains worksheets and self-monitoring diaries for users. These tasks enable consolidation of learning/progress. Ensure program contains a reflective space for users to personalise. These processes can be empowering in activating users to take charge and actively engage in their treatment and not be passive recipients of information. The process of writing itself can be of therapeutic value to clients (Pennebaker, Kiecolt-Glaser, & Glaser, 1988).

6.3. Supportive model: Online solutions differ on the extent to which personal support is provided/ available. Traditionally, dropout rates for online programmes have been high, one of the main reasons identified as a factor being lack of personal support. Richards and Richardson's (2012) review of the research flagged retention rates as an issue, having found that an average of 57% of users dropped out of online programmes. However they also found that personal support, in the form of any kind of personal contact by a supporter, significantly improved retention rates. They found that retention was significantly improved by the presence of some support, with dropout rates reduced to 28% for studies where therapist support was provided, 38.4% for studies where administrative- support was present and 74% for unsupported studies. It therefore appears that having any kind of personal feedback and contact is essential in promoting programme adherence and completion by preventing dropout.

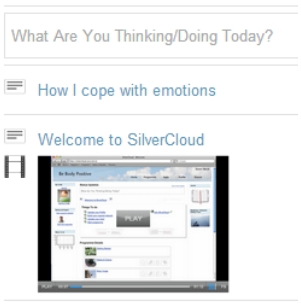
Ensuring treatment completion for a high percentage of individuals accessing treatment programmes is in line with best practice (e.g. NICE guidelines, 2009), which recommend some level of support be present and discourage unsupported self-help. It is therefore important to ensure that an online CCBT programme offers personalised practitioner monitoring, feedback and support for users.

6.4. Tailored to individuals— engagement: As well as ensuring that there is some support provided to users, it is also crucial to ensure client engagement in order to maximise retention and completion. There are several important ingredients that can promote individuals' engagement with online programmes:

- **non-linear delivery**
- **interactive multi-media content**
- **social and community features**



Tools & apps



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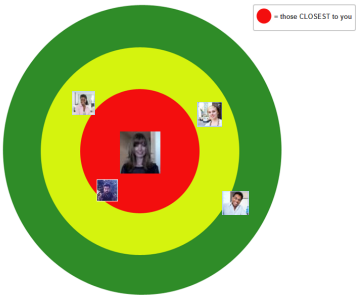
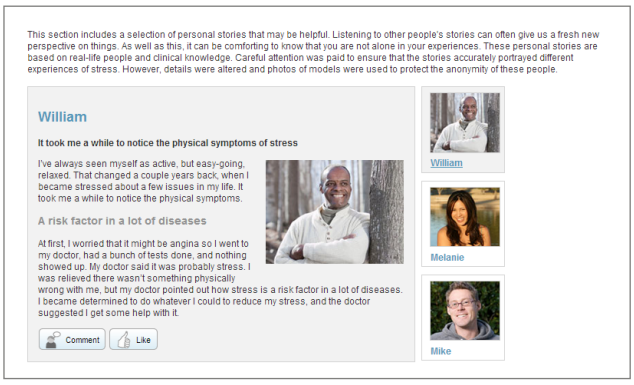


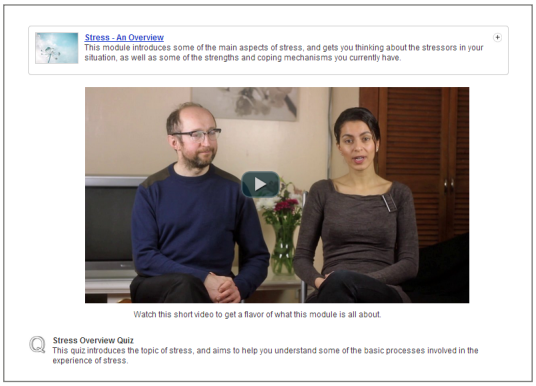
Support Network

6.5. Non-linear delivery: As online programmes have evolved it has emerged that users experienced being forced to work through a programme having to complete each section before being allowed to move on to a new one as frustrating and limiting. This can be particularly so when the content is also perceived as irrelevant to them or if they wish to jump back and forward to review different contents. Usage statistics from more recent technological solutions that are more flexible in their delivery of content and user navigation indicate that a substantial proportion of users take an exploratory approach to content, which may increase their engagement (Sharry et al., 2014). This may be facilitative in keeping their interest, therefore improving retention and programme completion.

6.6. Interactive, varied format: The format in which the material is presented also needs to be a consideration as not only different individuals have personal preferences and different learning styles (e.g. visual, verbal etc) but also, depending on their clinical presentation, concentration may be an issue. It is therefore particularly important that online therapeutic programmes include a variety of formats such as videos, quizzes, traditional text-based content, interactive activities, "personal stories", a personal space for users to personalise, a journal, charts, slideshows, and invitations to reflect and comment on content and activities. A wide variety of formats will try and ensure that a wide range of individual preferences is catered for, widening the reach and increasing the personal relevance.



Personal stories



Video

6.7. Sense of belonging: social and community: Another content feature that has been shown to be instrumental in promoting engagement, adherence, and completion and reduce dropout is the presence of community features. Community features can take the form of elements that enable users to share comments and content preferences with each other whilst remaining anonymous. These types of features can take the form of users ratings for particular programme contents, sharing tips and insights. These are types of community activities that have become familiar to many thanks to the widespread use of social networking sites and can therefore also add an element of familiarity. It has also been noted that individuals can enjoy and feel empowered in knowing that sharing their experience within a community could be helpful to someone else. Some users may still choose not to engage with such features in spite of their complete anonymity.

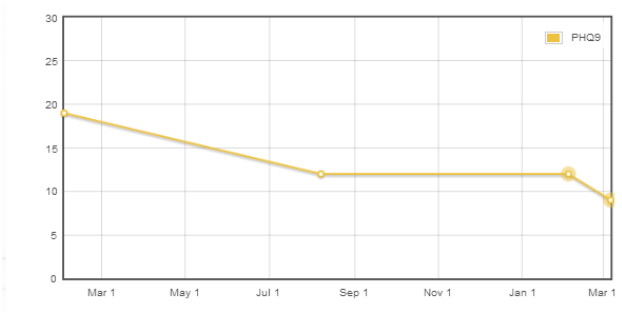
An online behavioural health and mental wellness solution:

- **Evidence-based CBT content**
- **In line with NICE guidelines: CBT protocols**
- **Supported**
- **Promote engagement: non-linear, interactive and include social & community features.**

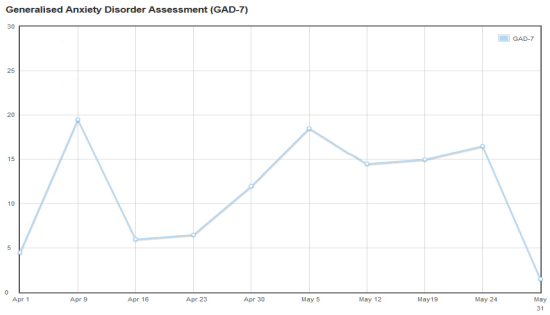
7. Platform capability.

The platform for the programme should be easily accessible by users and clinicians with the functionality to ensure that performance of the implementation of services can be monitored on an ongoing basis. One way to monitor performance is by using clinical outcome measures such as the Patient Health Questionnaire (PHQ-9) for depression and the Generalised Anxiety Disorder – 7 (GAD-7) for anxiety.

As this is a key element of service delivery, it is essential that the online programme platform should support the use and monitoring of these measures. These also benefit the ongoing clinical monitoring by clinicians collaboratively with clients and case managers, supporting them in the decision-making process of clinical evaluation and progression within the stepped-care model of service delivery.



PHQ9



GAD7

Platform to include:

- **An interface for the collection of outcome measures**
- **Facilitate collection of basic patient information**
- **Facilitate visualisaton of progress**
- **Accessibility – for clinicians and users**

It is important to evaluate the level of accessibility and how user-friendly the platform is. As one of the main factors for preferring using online services is convenience as patients may be too busy or logistically limited to attend for face-to-face appointments, it is important that the platform should allow for users to access the programme from a range of devices and locations to fit with users lifestyles. Access needs to be facilitative and user-friendly for clinicians so as to enable them to easily monitor client progress and provide feedback and support. It is therefore crucial to ensure any online programme platform can provide and implement the use of each of these elements.

8. Optimising an online solution into service provision.

Finally it is important to consider how an online solution can fit within the overall service provision of student services. As already mentioned an online intervention can be placed within a stepped-care model of service delivery as one of the evidence-based options for individuals. At the point of assessment a clinician would need to assess clients' needs, suitability and preferences. Clients who are suitable for the online solution would be then offered this as an option and, if agreeable, be referred to the online programme. A clinician could then be responsible for monitoring and providing feedback to clients using the programme.

It will be essential to understand accurately the importance of integrating an online solution into the clinical care pathway of any service. As a simple add-on there is a risk of minimizing the potential impact of an online solution. However, with accurate understanding of the clinical and care needs of clients in any service, a proper scoping of where and how best to implement an online solution would emerge. An integrated solution maximizes the potential impact of online delivered therapy.

Fitting an online solution into service provision:

- **As part of low intensity provision**
- **Screening and referring suitable candidates to online solution (see how to guide)**
- **Clinicians to monitor and give feedback**
- **Integrated solution as part of the clinical care pathways**

9. Conclusion:

Online programmes can be an ideal fit for Higher Education and contribute positively to their current targets of increasing access to evidence-based interventions and meeting growing needs among the student population. Higher Education need to consider a range of factors to ensure the technological solutions selected are evidence-based and contain a number of features to optimize outcome and increase retention and completion rates.

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