USING E-MENTAL HEALTH SERVICES

Evidence summary

There is an evidence base spanning two decades (Barak & Grohol, 2011), on the benefits of online mental health support, which continues to grow as technologies are being created, utilised and measured by practitioners, researchers and young people worldwide.

In this resource, some of the existing research evidence (primarily from the fields of social work, youth work and psychology) is explored to provide a broader understanding of the effectiveness and potential challenges of online mental health services and programs for young people and practitioners. As an emerging area of practice, the research examples cited are in no way an exhaustive list; however they are intended to provide an overview of the role and benefits of online mental health services, the dominant themes and findings of existing research and the risks and challenges posed to the young person and the practitioner.

The rationale for e-mental health services - benefits and risks

There is growing evidence that e-mental health services and programs have been effective in addressing the issues that affect the wellbeing of young people, such as depression (Andersson, Bergström, Holländare, Carlbring, Kaldo & Ekselius, 2005, cited in Abbott, Klein and Ciechomski, 2008), anxiety and stress (Barak et al. 2008), body image and related issues affecting eating patterns (Bruning-Brown et al., 2004, cited in Peng & Schoech 2008; Doyle, Goldschmidt, Huang, Winzelberg, Taylor & Wilfley, 2008) and alcohol and substance use (Squires & Hester, 2004; Buller et al. 2006).

There is a broad range of existing online interventions, many of which use interchangeable terms that describe similar technologies or processes (see the supporting resource 'Glossary of Terms').

Some of these terms, such as 'etherapy', 'cybertherapy' and 'therapeutic email' describe web or application based interventions in which a therapeutic process is assisted by the use of technology or in which the technology itself delivers the therapeutic support. Online support can be utilised in the many 'stages' of intervention such as health promotion, early intervention, treatment and recovery. Online service delivery offers practitioners further scope for what we understand to be 'therapeutic' for young people.

Whilst for some human services organisations and practitioners the use of digital technologies is relatively recent, practitioners, researchers and scholars have steadily contributed to this area of practice. Reamer (2013) provides a historical account for the use of digital technology in the provision of mental health services, such as self-help groups emerging in 1982 (Kanani & Regehr, 2003, cited in Reamer, 2013) and fee for service 'e-clinics' providing online counselling and therapy in the mid 1990's (Skinner & Zack, 2004, cited in Reamer, 2013). Helton (2003) and Barak & Grohol (2011) offer reviews on the types of online support that have emerged over the past two decades - highlighting that those with a stronger theoretical base are thought to be more effective.

Researchers such as Abbott, Klein & Ciechomski (2008), have created best-practice guidelines for practitioners providing online therapy and the National Association of Social Workers (NASW) of the United States have created standards for 'Technology and Social Work Practice' (2005). Research organisations have been formed to specifically study the benefits and challenges of online service delivery (for example, the Young and Well Cooperative Research Centre, Australia).

Benefits and risks

Research into the efficacy of online service provision by Benderly (2005), Barnett & Scheetz (2003), Childress, (2000), Grohol (1999, cited in Midkiff & Wyatt, 2008) as well as Mattison (2012), Barak, Hen, Boniel-Nissim & Shapira (2008), Abbott, Kline & Ciechomski (2008), Barak & Grohol (2011), Lal and Adair (2014) indicate common potential benefits. Their collective research also suggests that through a practice that consciously and explicitly negotiates potential risks, we can help mitigate any potential negative impact to both young people and practitioners.

Most commonly cited benefits include:

- the view that it is a response to the changing needs of our clients (King, Bambling, Llyod, Gomurra, Smith, Reid & Wegner, 2006)
- it provides a sense of immediacy in communication (Mattison, 2012)
- it can be delivered from multiple locations and offer convenience to end users by being available when they need the support (Lal & Adair, 2014)
- it can be cost-effective and reach a more diverse population (Barak & Grohol, 2011; Lal & Adair, 2014)
- it can offer an "increased perception of anonymity and accessibility for isolated or stigmatised groups" (Abbott, Kline & Ciechomski, 2008, p. 364)
- online interventions foster empowerment, which aligns with the professional values of social justice (Barak, Boniel-Nissim & Suler, 2008)
- in many cases it is comparable to face to face service delivery outcomes (Barak, Boniel-Nissim, Hen & Shapira, 2008) or provides new channels or options for service delivery, particularly for what is traditionally termed as 'outreach' services (Barak & Grohol, 2011).

Whilst more than one source highlighted the probable benefit, the citation offered provides more in depth discussion of the particular point.

Some of the most commonly cited challenges or concerns for providing online mental health services include:

- access to technology (a broader understanding of what 'access' can mean in Steyaert & Gould, 2009)
- lack of non-verbal or non-text based cues (Rochlen, Zack & Speyer, 2004; Mattison, 2012; Kimball & Kim, 2013)
- privacy and potential breaches of confidentiality (Midkiff & Wyatt, 2008; Mattison, 2012; Reamer, 2012; Reamer, 2013)
- boundary issues or concerns of dual relationships (Sanithiveeran, 2009; Reamer, 2013)
- informed consent, authentication of identity of clients or practitioners, and legal implications of providing services to young people from states or countries which have different laws than those of the practitioner (Recupero & Rainey, 2005)
- practitioner competence, uncritical use or unsupported referral to online support by practitioners (Suler, 2000; Day & Schneider, 2000, cited in Helton, 2003; Reamer, 2013)
- how support is terminated (Reamer, 2012; Reamer, 2013)
- how we document support provided or offered (Reamer, 2013)
- a lack of specific updated codes, standards or guidelines for online practice by professional bodies (Mattison, 2012).

An evidence based approach

Whilst the evidence base may exist to embed technology based tools into our practice, the benefits of any online mental health support on offer to young people needs to be assessed in relation to the nature of the support needed (with an awareness that this is not fixed), access to technology by both the practitioner and the young person, competence of use, informed consent, privacy and confidentiality. Barak and Grohol (2011) extend this notion further by stating that "we should also bear in mind that technology per se is socially meaningless; it becomes meaningful when it serves a significant cause" (2011, p. 170). In three meta-analyses focusing on interactive CBT based online interventions (Spek, Cuijpers, Nyklicek, Riper, Keyzer & Pop, 2007; Cuijpers, van Straten & Anderson, 2008; Cuijpers, Donker, van Straten, Li & Anderson, 2010) researchers confirm their effectiveness in addressing mental health concerns such as anxiety, however across the

studies the role of the practitioner was also deemed crucial, with "the time spent with the therapist remained the greatest predictor of positive outcomes" (Barak & Grohol, 2011, p. 164).

The implications of such findings for practice is twofold: firstly some researchers have advocated for online interventions that simulate the interaction between the practitioner and the client (Helgadótir, Menzies, Onslow, Packman & O'Brian, 2009, cited in Barak & Grohol, 2011); whilst others have highlighted the importance of the role that practitioners play in promoting and using online interventions, citing ethical obligations of practitioners to meet the needs of vulnerable people (Reamer, 2013) or returning to humanist principles of 'starting where the client is at' (Mattison, 2012). LaMendola (2010) argues that it is "presence" (2010, p. 108) or how we use 'self' that is at the core of social work or youth work practices and that this presence is "not confined to face to face encounters but [is] necessarily relational" (LaMendola, 2010, p. 108). He suggests that practitioners have a responsibility to inhabit "spaces where humans create associations, whether online or offline" (2010, p. 117) by expanding our concept of our own presence.

There are several key studies that highlight the effectiveness of online mental health services and some of the factors that can further improve outcomes. Peng and Schoech's (2008) research into online interventions found that the effectiveness of online services were improved when grounded in practice theories. They note that it is our practice theories that help us to shape, implement, evaluate and reflect on our online interventions; that is, that our practice theories help us tailor support for young people using both online and offline tools. Barak, Boniel-Nissim, Hen & Shapira's (2008) meta-analysis of 92 empirical studies focusing on online psychotherapeutic interventions, which involved 9764 clients, found that on average online interventions were comparable to parallel face-to-face interventions in effectiveness, that they had longer term benefits, and that those that were CBT based were far more effective than other therapeutic approaches applied online. The analysis also showed that online individual therapy was more effective than group based online therapy and that interactive online interventions seemed to have a more positive impact to participants than static information-based online interventions alone. They also noted that however, the effectiveness of CBT based interventions could be attributed to how evaluation is conducted when using clear models for practice and that there were less examples of studies on group based therapy.

Research examples

The following examples of research studies on specific programs are offered to further illustrate the range of technology assisted mental health support available, who they can serve and their outcomes:

An example of a web based service for young people:

ReachOut.com

"ReachOut.com is an Australian web-based service that aims to improve young people's wellbeing and prevent mental ill-health. First launched in 1998, ReachOut.com engages over 1.4 million unique visitors each year, making it one of the most widely accessed mental health services in Australia. ReachOut.com provides evidence based information and tools produced in partnership with clinical experts and young people in a variety of formats such as fact sheets and videos, personal stories, moderated online discussion forums (including both asynchronous and live discussions with peers and mental health professionals), online games, mobile apps and targeted social marketing campaigns delivered across traditional and social media channels. In a recent national survey of the service, 77% of young people accessing the site reported they were experiencing high or very levels of psychological distress at the time of visiting ReachOut.com. These figures are significantly higher than observed in general youth population health surveys and suggests that ReachOut.com is engaging young people who are likely to be experiencing moderate to severe mental health difficulties. Of the young people surveyed, 70% accessed the website between 5pm and 6am - when most other services are closed."

(Metcalf & Blake, 2014)

An example of a CBT based text messaging program

"In a randomised double-blind controlled study, Whittaker et al. (2012) drew on evidence based cognitive behavioural therapy techniques designed to prevent depression to deliver two mobile telephone messages to adolescents for 9 weeks. The intervention used 15 key messages derived from CBT. Intervention group participants reported that the intervention helped them to be more positive (66.7%) and to get rid of negative thoughts (50.2%), significantly higher than proportions in the control group, which received placebo messages focused on healthy eating, sustainability of the environment and safe practices for using the internet and mobile phone."

(Whittaker et al., 2012).

An example of an interactive website that offers CBT training for depression:

MoodGym

"MoodGYM, developed by the Centre of Mental Health Research at the Australian National University (2011), is an example of an online, self-paced, self-tailored treatment program for preventing and treating depression. Its interventions are based upon cognitive-behavioural and interpersonal therapy theories and are delivered through modules on its website. The program contains information, demonstrations, questionnaires, and skills exercises in areas such as problem solving, cognitive restructuring, assertiveness, and self esteem training. Research into MoodGYM has demonstrated its generally positive effects in helping reduce symptoms of anxiety and depression, in both adults and teens."

(Christensen, Griffiths, Korten, Brittliffe & Groves, 2004; Griffiths & Christensen, 2006; Griffiths, Christensen, Jorm, Evans & Groves, 2004; O' Kearney, Kang, Christensen & Griffiths, 2009, cited in Barak & Grohol, 2011).

An example of a study examining online information and online community:

"In a U.S. study of 238 college students experiencing mental health concerns accessing online support, researchers found that the two groups they studied - students who only viewed websites with information about student problems and students who viewed such a website and also had access to an online mutual support group - improved in wellbeing and satisfaction with life."

(Freeman, 2008, cited in Barak & Grohol, 2011, p. 167).

An example of a e-mental health program delivered using mobile phones:

myCompass

"Over 6 weeks, participants were given access to "myCompass": an interactive self-help program, which includes real-time self-monitoring with short message service prompts and brief online modules grounded in cognitive behavioural therapy. Preliminary analyses found that participants' symptoms of stress, anxiety, depression and overall psychological distress were significantly reduced after using myCompass. Improvements were also found in functional impairment and self-efficacy. This study supports the feasibility of implementing mobile phone-based interventions with the potential of improving psychological wellbeing."

(Harrison & Proudfoot et al., 2011)

An example of a collaboration between a U.S. national health service and Facebook:

Reporting a suicidal post

"The Substance Abuse and Mental Health Services Administration (U.S. Department of Health and Human Services) and the National Suicide Prevention Lifeline collaborated with Facebook to help people in crisis. The service enables Facebook users to report a suicidal comment posted by a friend to Facebook administrators by using either the Report Suicide Content link or the report links found throughout the site. The person who posted the suicidal comment will then immediately receive an e-mail from Facebook encouraging him or her to call the National Suicide Prevention Lifeline or to click on a link to begin a confidential chat session with a crisis worker."

(Substance Abuse and Mental Health Services Administration, 2011, cited in Barak & Grohol, 2011).

Self-help

In the area of health promotion and self-help, websites providing general mental health information to the broader population have been shown to educate and assist users with the concerns they have for their wellbeing (den Boer, Wiersma & van den Bosch, 2004; Freeman, Barker & Pistang, 2008 cited in Barak & Grohol, 2011). Websites can provide static information dissemination or can have varying degrees of interactivity. They can play an important role in not only providing initial information to end-users but also encourage further help seeking (Metcalf & Kauer, 2013). There are also websites devoted to assisting consumers make better choices on the quality offered by the websites they are accessing (www.discern.org.uk).

Blogs and peer-led support communities can also offer young people low to no cost support, information and an opportunity to express the issues that concern them. Self-directed writing such as blogging has measured therapeutic benefit (Possemato, Ouimette & Geller, 2010). Barak & Grohol (2011) suggest that blogging is an extension of traditional journaling techniques that complement intervention however, blogging offers the opportunity for interaction, thus "feedback from others can help an individual learn to view feelings, thoughts and situations in ways differently that they might otherwise" (2011, p. 168).

In a study of peer-led online communities, (Barak, Boniel-Nassim & Suler, 2008) found that some of the reported benefits of self-help or peer-led online communities were increased levels of wellbeing, self-confidence and a sense of empowerment by participants. Other studies by Barak (2011) and Barak, Boneh & Dolev-Cohen (2010) suggest that potential benefits are dependant on the level of engagement and interaction by community members (i.e. "posting new messages, replying to others, receiving replies" (Barak and Grohol, 2011, p. 167).

A recent study on young people who access the ReachOut.com website indicates that the site successfully reaches a target population of young people likely to be experiencing mental health difficulties who are not otherwise accessing professional support. The survey of an online self-selected sample of 5,283 non-professional users of the site aged 25 years and under found that 25% of young people who visit the site present with low levels of psychological distress and are generally seeking information to assist with school or university

related work. This reach highlights the potential for engaging these populations in opportunistic mental health promotion and universal prevention-oriented strategies. The study indicated that the majority of young people using ReachOut.com felt that it gave them the information they needed, that young people felt likely to return again in the future, and that over three-quarters would tell a friend about ReachOut.com if they were going through a challenging time (Metcalf & Kauer, p. 2013).

The use of online self-help strategies can also be of benefit for young people already accessing mental health services. In a systematic review of studies which focused on online self-management interventions for people diagnosed with psychosis, researchers found that end users were able and willing to use e-mental health services, that e-mental health services are at least as effective as usual care or non-technological approaches, and that there were other positive impacts on medication management (Van Der Krieke & Wunderink et al., 2014).

Building social-connectedness and social-belonging

Online mental health services can offer young people a greater sense of community and belonging. Research is positively linking many types of online mental health support with increased feelings of connectedness to others. Rather than being viewed as impersonal, technology assisted support is connecting practitioners to young people, young people to other young people and young people to information and knowledge "thereby decreasing feelings of social isolation" (Johnson & Ashton-Shaeffer, 2003, cited in Mattison, 2012, p. 257).

In studies that focus on online groups, researchers are finding that young people are developing less physically bound definitions of 'community'. Baker & Moore's (2008) study into the effects of blogging found that the sample group (Myspace users) who blogged frequently had higher satisfaction scores in the areas of social integration and friendship than those that did not blog. Cited in Barak & Grohol (2011), Ko & Kuo (2009) found that increased levels of self-disclosure by those that blogged promoted other areas of their wellbeing such as social integration, social capital and happiness. Peng & Schoech's (2008) research review concluded "online interventions are more effective when they build on social and cultural networks of family, mentors, peers and other influential groups; for example peer discussion groups and parent involvement in change" (2011, p. 391).

How practitioners themselves are utilising online communities, is also an emerging area of research. Youth and social workers are also using online communities to highlight practice concerns with colleagues, applications like Twitter and Facebook to raise awareness of social issues affecting their client group, and blogging for critical reflection of practice (Hickson, 2012).

Building mental health literacy

Barriers to seeking face-to-face assistance for mental health concerns, such as stigma or access can limit young people's mental health literacy (Biddle, Donovan, Sharp & Gunnell, 2007). Research is increasingly indicating that more and more young people are going to online spaces to retrieve mental health information (Gowan, 2013; Metcalf & Kauer, 2013), which can have both positive and negative implications on their developing mental health literacy.

In an exploratory study on how young people with diagnosed mental health conditions are using the internet to access mental health information, Gowan (2013) found that young people in the study were accessing information related to their mental health for varying reasons that were unique to the online experience. Whilst a small study, the themes that emerged have implications for our practice with young people. The study found that young people were actively searching for information on medication, diagnosis, treatment options, access to services and supports online because they needed additional information after a face-to-face visit, for a sense of community, because they felt they had nowhere else to turn to, to prepare for a health visit, and because it offered them anonymity (Gowan, 2013). Gowan (2013) also found that young people were going online to develop their mental health literacy in order to "challenge what they hear from a health care provider" (2013, p. 108). Participants of the study also had concerns about the nature of online information such as feeling overwhelmed by the magnitude of information and not always trusting of the quality of the information given. These findings present opportunities for practitioners to engage with young people about the online support they are accessing or wanting to access.

Research into the area of quality and accuracy of online mental health has had mixed findings, with some studies indicating that quality is low (Reavely & Jorm, 2011, cited in Gowan, 2013). Other studies explore sources of online information that are reinforcing distressing behaviours such as sites about suicide methods or how to become more anorexic (cited in Barak & Grohol, 2011, 168). As the quality of the information or support accessed by young people online can be so varied, as practitioners, we can have a significant role to play in developing mental health literacy as a dialogue between young people and ourselves. Gowan (2013) suggests that "it may be useful to teach young adults how to search effectively for health information online, and also how to evaluate the quality of that information once found" (2013, p. 108).

Betton and Tomlinson (2013) suggest that the only way practitioners are to play a role in guiding the use of online mental health support and assisting clients to making informed choices, is to learn more about the types of support available and have conversations (online or offline) about what clients are accessing or finding helpful online. In this way we can share emerging mental health literacies.

Improving help-seeking

Research confirms the practice experience that our clients are increasingly seeking mental health information and services online (Anderson & Guyton, 2013). Rickwood & Mazzer (2012) suggest that factors related to identity formation, public and personal stigma, and external supports available to the young person during the period of adolescence have an impact on help-seeking behaviours.

In a meta-analysis of research into the impact of online services on help-seeking, it has been identified that there is little research that specifically examines the impact of e-mental health services on further help-seeking (Kauer, Mangan & Sanci, 2014). More research is still needed to conclusively determine the kinds of online services that encourage professional help-seeking. However, the results did show that young people regularly used these online services, and found them easy to use and beneficial. Further, they indicated that the online services examined appeared to impact important help-seeking barriers such as mental health literacy.

In a study on young people using online counselling, King, Bambling, Lloyd, Gomurra, Smith, Reid & Wegner (2006) found that they reported a greater sense of comfort in e-mental health spaces, attributing this to a feeling of being better able to control their questions and responses, thus making them more likely to engage in seeking further assistance.

Results from a recent evaluation on ReachOut.com indicate that the site is positively influencing young peoples' help-seeking intentions, and therefore continues to offer significant potential for facilitating help-seeking behaviour. In particular, a high proportion of respondents who were experiencing high or very high levels of psychological distress indicated they were more likely to seek support from a medical doctor (29%) or mental health professional (41%) after visiting ReachOut.com, despite having not previously accessed any form of professional help (Metcalf & Kauer, 2013).

Managing boundaries in online spaces

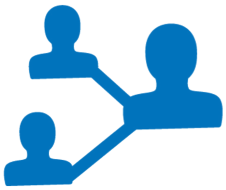
Related resource

Please also see the ReachOut.com Professionals professional development module:

Connecting Our Worlds, Part 4: 'Professional issues, boundaries, privacy and guidelines', (2011)

for practical strategies in managing ethics and professional boundaries online, such as how to manage Facebook 'friend' requests & managing your online time.

► au.professionals.reachout.com/Part-4-Ethics-and-boundaries



Our professional practice codes and standards as well as our organisational policies provide guidance for the management of professional and personal boundaries. The Australian Association of Social Workers (2010) state that *"Social workers, not their clients or former clients, are responsible for setting and maintaining clear and appropriate professional boundaries in all forms of communication, including face-to-face contact, written communication, telephone and online communications (including social networking, email, blogging and instant messaging)* (2010, p. 22). Whilst many practitioners have a good understanding of the impacts from how they manage boundaries in a face-to-face relationship with a young person, the ethical challenges that professionals are presented with when they share online and offline relationships with young people can be less familiar.

The body of research, particularly into the online practices of social workers and psychologists, now spans over 20 years. Research suggests that our competence and skills as practitioners in face-to-face interactions with young people do not always automatically translate across into our online service delivery. Evidence and practice research over this period highlights many professional and personal challenges as well as our ethical concerns when we adopt online technologies into our day-to-day practice (Cwikel & Cnaan, 1991; Marlowecan, 1997; Lie, 1997; Ballantyne & LaMendola, 2010; Anderson & Guyton, 2013; Reamer, 2013).

In addition to understanding the broader benefits and potential risks of online service delivery, practice research indicates that youth and social workers need to be more aware of the differences of online communication styles in order to effectively manage

professional and personal boundaries (Shapiro & Schulman, 1996; Kimball & Kim, 2013; Reamer, 2013) and potential risks when lack of physical cues create ambiguity of meaning (Midkiff & Wyatt, 2008; Mattison, 2012; Kimball and Kim, 2013). Research suggests that practitioners mitigate possible issues related to miscommunication through incorporating techniques such as 'emotional bracketing' (Murphy & Mitchell, 1998, cited in Mattison, 2012) whereby the writer specifies the emotional tone of the written text in brackets, through the use of emoticons or through the creation or adoption of an online communication etiquette (Mattison, 2012). Whilst some studies have found that there is concern amongst practitioners about incorporating online service delivery methods into their practice (Finn, 2006), others have identified that rather than being purely a substitute for face-to-face interaction, online mental health services provide an extension of the relationships (Murdoch & Connor-Greene, 2000, cited in Mattison, 2012) between practitioners and young people.

Earlier practice research by Gutheil and Simon (2005, cited in Anderson & Guyton, 2013), suggested that online practices could create what they termed a 'slippery slope' when it came to how we can blur boundaries in professional relationships. From their research into the practices of psychologists, social workers and physicians, they suggest that developing professionals "could benefit from guidance when it comes to managing their personal life online" (Anderson & Guyton, 2013, p. 116). Online mental health is a dynamic and developing area of our practice. Even practitioners who are familiar and competent in online service delivery can benefit from continued training to safely embed emerging tools into professional relationships with young people (Finn & Barak, 2010). Some studies have found that practitioners search for online information about their clients, which can pose ethical and legal implications (Clinton, Silverman & Brendel, 2010; Dilillo & Gale, 2011, cited in Barak & Grohol, 2011). Other studies have focused on the differences between levels of self-disclosure online and offline and have found that practitioners often provide information on social media profiles that they would not in the context of their professional relationship with clients (Anderson & Guyton, 2013). This raises implications for the professional relationships we aim to build with young people, particularly in relation to transference and countertransference (Reamer, 2013).

How the practitioner inhabits online spaces in a personal capacity needs to be considered when negotiating professional boundaries and this is an emerging area of research inquiry. Kimball & Kim (2013), identify several questions that the worker can use to guide their use of online spaces when considering how they maintain professional boundaries in both professional and personal contexts (Kimball & Kim, 2013, p. 187) and argue that social workers "need to be aware of the identities they create and maintain in the realm of social media because of ethical codes and policies" (2013, p. 185). Kimball & Kim (2013) go further to suggest the notion of maintaining 'virtual boundaries', particularly in relation to the use of social media, with a clear understanding of how our professional and personal connections intersect on a daily basis. The implications for practitioner self-care strategies is also an emerging area for practice research.

Concluding notes

This document provides an overview of the evidence base for online mental health programs and services, and some of the broader implications for practice. Human services practitioners have started to incorporate these implications into existing practice frameworks - negotiating a place for the use of new technologies and emerging online practice methodologies within existing codes of ethics, standards and practice theories. The Australian Association of Social Workers (AASW) for example, outlines the specific responsibilities of practitioners who utilise technology in service delivery in their Code of Ethics (2010) under the section 5.5.4 which guides all remote service delivery (2010, p. 39).

Whilst professionals use existing codes and standards such as the AASW Practice Standards (2013) for social workers - which guide all professional practice contexts, some scholars have noted tensions between what is currently included and what may be within practice experience, but excluded from such guides. Mattison (2012), states that practitioners "are justified in being duly cautious of adopting online technologies into their practice until newer standards are added" (2012, p. 256), whilst other practitioners argue that existing codes and standards are a strong foundation for ethically sound practice whether online or offline. Betton and Tomlinson (2013), in a guide for digital innovation in health care for the National Health Service of the U.K., state that *"mental health services manage risks day-to-day and help people they support manage risks in their everyday lives"*. On the whole most of us learn to manage those risks. Social media is the same – with two caveats. The speed of activity in social media is phenomenal. And once a post is published online, it is there forever – often referred to as a 'digital footprint'. No manual on how to use social media will ever lay down rules on what you should do. It is individual and what works for one person, could be unhelpful for another" (2013, p. 9).

As practitioners, we negotiate our understanding of working with young people based on standards and codes that are not always explicitly reflective of our practice realities. Our day-to-day practice offers us opportunities for creativity and innovation that we can further explore with research methodologies, some of which are emerging themselves due to possibilities of technological application.

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