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The Berkman Center for Internet & Society
at Harvard University

Evaluating Online Safety Programs

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About Sharptalk

We gratefully acknowledge the support of National Institute for Health Research (NIHR), which funded Sharptalk under the Research for Innovation, Speculation and Creativity programme. For more information about Sharptalk visit:
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Outline

This essay describes the process of developing and evaluating an online safety program (Sharptalk). It explores the challenges faced, particularly when working with vulnerable groups, in this case, young people who self-harm. Highlighted is the complexity involved in understanding how what you are trying to do may or may not work, as well as understanding the intended and unintended consequences of a program. Unintended consequences are a particular cause for concern; young people we work with who self-harm often describe self-harming as an emotional coping strategy and one that prevents more extreme behaviour, for example, suicide. Therefore a program that aims to reduce self-harm, or limit, censor and control the discussion about self-harm among young people may actually increase the risk of harm and not reduce it as intended.

Recent work reports that a key message from young people is that they need support which is non-judgmental and respectful. We know self-help as critical and that a 'one size fits all' approach is unacceptable. Therefore, we suggest that the creation of safe spaces in which young people and health professionals can explore issues together, where conversations are 'moderated' and disclosure of self-harm can take place without panic, revulsion or condemnation, are both safe and desirable among young people. We also suggest that these spaces may represent one of the strongest types of interventions available to young people, although more work needs to be done in this area.

While more research in how online safety affects people who self-harm is needed, how best it is done remains a challenge. In our experience, research ethics committees (IRBs) appear to lose their objectivity when considering research areas such as the Internet and self-harm and appear overprotective for potential participants. Research Ethics Committees seem to impart incomplete or incorrect knowledge, particularly in areas such as the increase of risk and the likelihood of 'suicide pacts' due to the increase in conversations about self-harm. Although it is clear that there are no simple answers; issues young people face are not black and white, similarly neither should our responses to these issues be black and white.

Central to establishing whether online safety programs are effective is ensuring that they run within a robust evaluative framework. However, in our experience there is not always an inbuilt evaluative component to online safety programs. Many are developed from a practitioner perspective where evaluation might not be the key issue. In addition, it might be argued that in some cases those developing such programs lack the methodological training to appreciate the implications of evaluation. For example, one particular program within the UK has been very effective at disseminating information about online safety practice, but evaluation has been based upon paper based evaluation forms at the end of training sessions. However, data input was not factored into the program which has resulted in a vast archive of unanalyzed, paper based data. Therefore, we would propose that along with more research we also suggest the need for the systematic development of pragmatic evaluative guidelines for safe and appropriate use of the Internet by vulnerable children and young people.

Online Safety: Context

To summarize the empirical data from a number of reviews (1-3) it is clear that the greatest risk children and young people face is not, contrary to popular media reporting, sexual solicitation and grooming, rather exposure to (and creation of) 'inappropriate' content and cyber bullying. There is also growing understanding of the role of the young person as perpetrator, as well as victim, of harm as a result of online interaction. However, a significant gap in the literature to date is how the 'risks' and 'dangers' of the internet affect those who are considered 'at-risk' or 'vulnerable'.

In the UK, OFSTED (Office for Standards in Education, Children's Services and Skills) in response to the Byron Review, has begun to evaluate the extent to which schools teach pupils to adopt safe and responsible practices in using new technologies¹, in particular, the internet and social network sites.

The response taken by a wide range of groups, organizations, the government, charities, schools, etc. has been to develop online safety programs. By and large, these programs are based on some of the empirical research. However, and in light of the actual evidence, the overwhelming focus is still on keeping children and young people safe from sexual predators. This would suggest that program development is sometimes based more on reaction to media influence, rather than considering the available data and literature around young people's online behavior and the threats therein.

Good Practice Example

In one local authority, the schools adopted a 'think before you click' policy. From an early age, pupils were taught that, before clicking onto a site, they should ask questions such as:

- who wrote the material on this site?
- is the information on it likely to be accurate or could it be altered by anybody?
- if others click onto the site, can I be sure that they are who they say they are?

Assumptions are made in how online safety programs have developed, principally, that the approach should be no different to how we think about managing risk for children in the offline world. While this is a sensible and valid starting point, it is at risk of not recognizing the growing lack of distinction young people make between online and offline spaces.

Across the wide range of online safety programs few have been robustly evaluated (4). By this, we mean that the approach taken has significant flaws, subsequently this means that the true picture remains unknown. Therefore in many cases, we still do not know if *program x* is better or worse than *program y*, or whether *program c* even works at all. Where any of these programs look helpful, it is still not known what it is about them that makes it work or who it might work best for.

¹ [http://www.ofsted.gov.uk/Ofsted-home/News/Press-and-media/2010/February/Students-safest-using-the-internet-when-they-are-trusted-to-manage-their-own-risk/\(language\)/eng-GB](http://www.ofsted.gov.uk/Ofsted-home/News/Press-and-media/2010/February/Students-safest-using-the-internet-when-they-are-trusted-to-manage-their-own-risk/(language)/eng-GB)

Finally, it remains almost impossible, using data from the online programs evaluated so far, to establish whether 'outcome measures' (what it is they expected to see change) were defined, measured or met.

The overall trends on online safety appear to be showing a reduction in inappropriate contact and access/creation of inappropriate content, but, it is not really any clearer why this is. This could be for a number of factors- the fact that there are any number of online safety programs that are running; young people's peer support approaches (as a result of the fact that awareness programs are fragmented and sometimes relate to adult projection of risk rather than reality), or simply that young people are more online savvy than those developing programs credit. Trying to understand what has caused overall changes is fraught with complications. We suggest that while we can describe changes have taken place over the last five or so years, given current data we can not be certain that online safety programs are actually responsible for this change.

When how a program might work has not been defined, we can never be certain of why changes in behaviour happen. The changes observed could be due to general, non-specific trends that might have happened for other reasons. Following on from this, while we might be reasonably certain of the different parts of a program, how they work when combined may or may not have the desired impact. In a healthcare setting, we often call the thing we want to do an 'intervention'. Interventions range from simple to complex. We must note though, that even something that looks simple may still be complex. To illustrate; a smoking cessation program may start with the GP prescribing nicotine replacement patches. The GP knows from previous research that the patches can prevent cravings. At this level, the intervention is simple, however, it becomes complex as prescribing the patch is the only thing the GP actually has control over. Once the patient leaves the pharmacy a number of things may affect how well the patch works. This includes events such as whether or not it is worn, smoking habits, social interactions that either support or challenge, stressful events, strength of cravings, exposure to media portrayal and so on. An intervention that appears simple and proven is actually quite complex.

At this point, it is important to describe the difference between complex and complicated. Essentially complicated means that something is difficult (or not simple), but ultimately knowable. Complex means that something is not simple and NEVER fully knowable because too many things interact. For example, the wiring on an aeroplane is complicated as ultimately it can be learnt and the laws of electronics will dictate how things happen. Bringing up a baby is complex, no book or diagram can ever really explain how to do it (although plenty try!).

Developing our Intervention

Context

The importance of consumer involvement in healthcare is widely recognised, and is central to the Department of Health's strategy for modernising the English National Health Service (NHS) and improving the quality of care. (5-9). Much has been written about the benefits and challenges of involving service users in research(9-13), in service planning and development and in the education of healthcare

professionals. (14-16). Far less attention has been given to the impact of consumer involvement in intervention design. Within healthcare, the science of intervention development is still in its infancy. (17, 18). Few studies report the development process, giving the impression that interventions emerge ‘out of thin air’ and proceed straight to a definitive research trial.

Lack of clarity in this area was one of the factors that prompted the recent revision of the UK Medical Research Council’s (MRC) guidance on development and evaluation of complex interventions. (19, 20) The new guidance states that ‘best practice is to develop interventions systematically, using the best available evidence and appropriate theory.’ Emphasis is placed on good preparatory work, including, where necessary, new primary research, such as conducting interviews with those targeted by the intervention, in order both to develop a thorough understanding of the likely process of change and to ensure acceptability.

In terms of exploring whether something works or not, there are a number of challenges faced. To frame these challenges, it is worth illustrating how a typical research process designs, tests and implements an intervention.

At various stages through the MRC guidance, questions are asked to help those trying to understand how well an intervention might work.

- Are you clear about what you are trying to do: what outcome you are aiming for, and how you will bring about change?
- Does your intervention have a coherent theoretical basis?
- Have you used this theory systematically to develop the intervention?
- Can you describe the intervention fully, so that it can be implemented properly for the purposes of your evaluation, and replicated by others?
- Does the existing evidence – ideally collated in a systematic review – suggest that it is likely to be effective or cost effective?
- Can it be implemented in a research setting, and is it likely to be widely implementable if the results are favorable?
- Have you done enough piloting and feasibility work to be confident that the intervention can be delivered as intended?

What is a complex intervention
Complex interventions are widely used in the health service, in public health practice, and in areas of social policy such as education, transport and housing that have important health consequences. Conventionally defined as interventions with several interacting components, they present a number of special problems for evaluators, in addition to the practical and methodological difficulties that any successful evaluation must overcome. Many of the extra problems relate to the difficulty of standardizing the design and delivery of the interventions, their sensitivity to features of the local context, the organisational and logistical difficulty of applying experimental methods to service or policy change, and the length and complexity of the causal chains linking intervention with outcome.

Being ‘at risk’

As already described, the biggest gaps in what has already been published is how the ‘risks’ of the internet affect those who are considered ‘at-risk’ or ‘vulnerable’. Taking the MRC guidance in hand Our (Tobit’s) research team set about applying it

to the development and testing of two different interventions. 1) a SMS text message service for people who self-harm and 2) the creation of a safe online space (discussion forum) where people who self-harm can talk to each other and health professionals.

When developing our SMS intervention we speculated that the 'always on', instant, low-threat medium of text-messaging might offer an interactive lifeline to those at risk of self-harm, and set out to explore its potential as a cost-effective medium for delivery of a low-intensity intervention to provide psychological support following a visit to A&E (Accident and Emergency / ED Room). Through a series of workshops, we set out with the goal of answering significant question: how to get the right message to the right person at the right time in order to reduce the urge to self-harm. At the end of the third workshop, the group was still unable to reach agreement on a set of messages that might 'work' in all circumstances to reduce the urge to self-harm or enable people to feel cared for. Through extended discussions, it emerged that, while each service user could identify several messages that might reduce their own risk of self-harming, they were unable to say whether or not these would help another person in another situation. There was also concern it could make things worse. Grasping the significance of this was vital. It was clear that not only were the intended or expected consequences challenged by people who might typically receive the intervention, we also had to unpick a series of possible unintended consequences.

Sharptalk, our safe space for young people and health professionals to meet and talk about all things, but mostly self-harm, grew out of our understanding of the tension between how young people use the internet and how health professionals and the NHS operate, including how they use the internet. We know that young people currently present a challenge for the NHS (UK National Health Service), inasmuch as they are often reluctant to consult health professionals, particularly for emotional and psychological problems. (21-23). When seeking help for mental health problems, adolescents look for several characteristics in potential helpers; including being non-judgmental, able to 'relate to teens', and making themselves available. Other studies of adolescent help seeking have shown a preference for non-judgmental and genuine support, as well as for younger health professionals. (24).

There are many Internet forums specifically devoted to the subject of self-harm, and these raise particular concerns. It is widely believed that some unmoderated sites pose considerable risks to young users. (25-27). However, emerging research also illustrates the supportive nature of online self-harm groups. (28). Users on Sharptalk were clear, they wanted a moderated site. (29).

The recent Mental Health Foundation report on the National Inquiry into Self-harm among Young People (30) highlights a key message from young people that they need preventative measures which are non-judgmental and respectful. The report goes on to identify self-help as critical; that a 'one size fits all' approach will not work and that work is needed to build the confidence of those closest to young people so that they 'can hear disclosures of self-harm without panic, revulsion or condemnation'.

We know that non-fatal self-harm is one of the strongest predictors of suicide. Although only a small number of those who present at A&E departments following self-harm each year will go on to kill themselves, those who engage in self-harm

remain more than a hundred times more likely to die by suicide than the general population. (31, 32). Despite this, we know that self-harm can actually function as a way to protect against suicide and to 'safely' manage emotional turmoil.

Again, we speculated that online support has the potential to bring the NHS (and other care providers) closer to identifying and meeting the needs of young people with experience of self-harm. The Sharptalk study aimed to explore the potential of an online environment to foster engagement between health professionals and young people who self-harm. Young people experiencing emotional and psychological difficulties are often reluctant to seek help from health professionals and, when they do, professionals can lack confidence in how to talk to them. This is particularly true for self-harm. The researchers wanted to know whether young people and professionals could be encouraged to communicate with each other anonymously within a virtual space and to learn from one another.

In order to achieve this aim we set up an experimental online discussion forum and recruited young self-harmers (aged 16-25) and recently qualified mental health professionals (5 years or less).

Ethical Dilemmas in Intervention Design

From an ethical point of view, designing Sharptalk was exceptionally challenging and it took our team nine months to secure approval for the project. We felt that the promise of anonymity was essential in order to encourage young people to participate, but it meant they had no way of verifying participants' identities. It also meant there would be no way of intervening in the event of a crisis, such as a suicide threat. There were questions about whether taking consent online is acceptable and other concerns about how to ensure the safety of participants within the forum. Safety of the researchers was also an important consideration and the study team was supported by an independent panel of experts on child protection, ethics and medical law.

Central to the Research Ethics committee concern appeared to be the increase of risk and the likelihood of 'suicide pacts' due to the increase in conversations about self-harm. Set in the context of self-harm as a risk factor for suicide, one can understand the, albeit misinformed, view of an ethical committee faced with such an intervention.

Parents, teachers, children, young people and peers are exposed to a wide range of good citizenship material. That is, we are attempting to teach children and young people how to behave in a way that society feels appropriate. We attempt to reduce racism, stigma associated with mental health illness, bullying and so on. We teach children to embrace diversity, to be inclusive and to speak out on social justice matters (something new media facilitates well). Essentially we have and continue to coach children and young people to look out for their friends, support, care and nurture each other as they grow and develop. Herein lies a challenge. One study on self-harm forums (33), reports that the theme the authors felt had the most potential to harm was the de-emphasizing of self-injuring behavior. If a member reported self-injuring and appeared upset about what they termed a "slip-up," the other members often provided support and made their presence known by stating "I read, I care, I

listen.” It was common to treat the self-harming incident as a normal occurrence, which the authors feared might perpetuate self-harm by creating a community wherein it is accepted behavior. The very responses that we want young people to have (for example to not judge, humiliate or alienate) is suddenly deemed wrong in a certain setting. In our research we have consistently found that there are potential unintended consequence of reducing self-harm. The people we work with tell us that if self-harm is prevented it might also increase the risk of suicide. This is because self-harm is often used as a way to cope—the one thing someone could do where they had some way to control or mediate their emotional state. we suggest that the normalization risk is not as black and white as it may seem. Simple interventions to stop or decrease self-harm may result in an increase of more (socially acceptable) risk-taking behaviors or suicides.

To both satisfy the ethical requirements, and to promote safety of our participants, research team and moderators we put in place a number of measures.

We took consent online but used a 2-stage process, with a 2-week window between stages, to ensure that participants had adequate time to consider whether or not to take part and required a certain level of commitment in order to proceed.

Once enrolled in the study, participants were required to abide by ground rules and a team of trained moderators monitored the site daily (Research Ethics (IRB) requested 24h moderator cover, we agreed a pragmatic compromise based on activity. After the first week we observed site activity would taper off around 2AM and adjusted moderator cover to suit.) to check that everyone was complying with them. The rules included basic ‘netiquette’ (e.g. no abusive or offensive posts, no advertising) as well as specific rules relating to self-harm, such as not sharing tips on how to self-harm or giving graphic details of methods. There was also guidance on labeling posts as potentially ‘triggering’ (i.e. likely to make someone feel like self-harming), suggestions of alternative things to do if you feel like self-harming. A dedicated ‘crisis room’ within the forum provided a container in which participants could seek help with particular issues and support each other in difficult times.

The issue of ‘non-intervention’ was the most contentious issue by far. The fear was that if a participant indicated online that they were about to make a suicide attempt, we would have no way of alerting emergency services. We considered various ways of tracing the whereabouts of a participant in a crisis, but none was feasible and there was no guarantee that we would be able to intervene, even knowing the person’s location. We developed a risk-management protocol with our Ethics Advisory Group and this was available for members of the team to follow in a crisis, including using the ‘private messaging’ facility, urging the individual to seek help and providing contact details of relevant agencies. Clinicians were on call throughout to provide advice.

Relating Online Safety Programs to Self-Harm

Increasingly, young people appear to rely on peer-to-peer advice and support that is available online through chat rooms, forums and bulletin boards. The advice of peers, grounded in lived experience and a shared understanding of how it feels to be young, appears to be perceived as more relevant and trustworthy than that of experts. (28,

34).

If NHS professionals wish to engage with and disseminate reliable health information among young people, they may need to find a way to work in and with online or 'virtual' communities, in much the same way that health promotion specialists work internationally with real-world communities.

There is currently limited evidence on the ways in which online communities are being used for health education and information-gathering, on their impact on health behaviours and on the most appropriate models of online health promotion. (28, 35-37). A recent systematic review (38) on internet support groups for depression found a lack of evidence about their nature, usage, outcomes and comparisons with other online support groups for different types of conditions.

Although there is increasing emphasis for professionals and healthcare students to take account of people's experiences of services, training about self-harm is often focused on risk management and omits issues relating to coping, even among mental health professionals. Thus, healthcare staff coming into contact with young people who self-harm are often woefully ignorant about how to support them and may be personally challenged by this type of behaviour. (39, 40).

New media have the potential to bridge the communication gap between young people and health professionals. (41-43). By working collaboratively within online communities, healthcare students, as well as established professionals, could benefit from learning from young people about their healthcare concerns and experiences. In other words, online communities may have a role to play in professional, as well as public, education. (44).

Some education based models may have potential to improve engagement between young people who self-harm and health professionals. Health promotion is a process directed towards enabling people to take action and involves collaborative working between individuals or groups. Arguably this approach strengthens the skills and capabilities of individuals to take action and the capacity of groups or communities to act collectively to exert control over the factors of health and achieve positive change. While Sharptalk was designed and implemented primarily as a space to explore self-harm and related issues and not as a self-harm reduction intervention we did set out to promote individual empowerment and autonomy; providing individuals with sufficient information to motivate them to use self-protection measures; and encouraging clients to implement self-protection measures in real life.

The concept of harm is widely (though not necessarily) is often conceived in objective terms - taken to be observable by others - and is hence measurable in a reliable fashion. When it comes to children, adults and policy makers want clear 'evidence' of what is 'harmful' and turn to research evidence to find this. However, we have seen through the examples of both the SMS text message work and the Sharptalk study, that finding clear, black and white evidence is not straight forward. This is because deciding what is appropriate or inappropriate is subjective and based on many factors including the age, experience, values, belief systems and the culture of the person making that decision. We plan on exploring these issues further in our Sharptalk study, as we believe, based on our work so far, that by creating a safe and authentic online space, supported by the NHS, may act as a type of intervention helping to support a population of people who are vulnerable.

Evaluating our Intervention

The Sharptalk study was a short, experimental piece of work that set out to address the often repeated call for more research, especially in relation to vulnerable groups and the creation of problematic content such as talk, pictures and videos about self-harm.

We set out to observe, interact and study in a safe and ethical way. However, many questions still remain. We need to evaluate further and this might include further exploration with young people about what good is.

We collected data on: socio-demographics; self-harming behaviour; internet habits and help-seeking behaviour. Data was collected from all participants as part of the consent process, via a short online questionnaire.

Online communication took place in either 'threads / topics' or via private messaging.

Following Sharptalk site closure, threads and private messages, were archived for analysis

General evaluation of Sharptalk was undertaken via an online questionnaire, including views on:

- forum size
- experience of taking part in SharpTalk
- Moderation

The survey was developed out of participant comments in Sharptalk. A keyword search relating to the above issues was undertaken and resultant comments were converted, via six iterative team discussions (for editing and clarification), into succinct thematic, unique, rateable and anonymous statements.

For practical purpose, the draft questionnaire was condensed through a consensus process, and a self-harmer and professional version produced.

A mix of rating, frequency and quantity scales were used. Participants were able to add clarifying comments.

Finally we collected Data about the way in which participants logged on and posted. Episodes (period logged in) were calculated from participant usage recorded by the forum software.

We used discourse analysis (DA) to explore the way in which participants engage with each other and professionals in the online groups. DA was also used to explore the ways in which participants used language to support each other and manage sensitive issues online. Thematic analysis was used to analyze participants views and perspectives using standard research approaches.

We used a variety of approaches to improve both measurement related and interpretative rigor in our mixed methods research.

We will continue to evaluate not just what we are doing, but how we are doing it (sometimes called process evaluation). This will help us to explain discrepancies between what we expected to happen and what we observed actually happening. This will assist us in understanding how context influences outcomes, and will also provide insights to aid wider implementation.

Our experience tells us that a good theoretical understanding is needed, both of the problem to be addressed and of how the intervention might cause change, this way, we are in a stronger position to identify weaknesses, understand intended and unintended consequences and can subsequently strengthened what we do.

Other Considerations

Most programs or interventions, when translated from the controlled research environment into an everyday setting move the program from a theory to an activity that is socially embedded and contextually framed. The realist evaluation approach, addresses this, in part, by not asking 'Does this program work?' but instead, 'What works for whom in what circumstances and in what respects, and how?'

In a wider context, many health and social care improvement programs invariably emerge from a research setting, where as much as possible has been controlled for (differences in age, gender, emotional state, any diagnosis, etc.). This means that as far as possible, all the contextual, social, biological and other factors are managed. Research interventions are also followed very closely due to higher levels of scrutiny. Subsequently, we need to be aware that when the results suggest something might work, we know it worked for the research population. Depending on how well the intervention was designed, developed and tested will give strong indications of whether the intervention will work for other people (can the results be generalized to the whole population). The more complex a program or intervention becomes, the harder it is to define what is actually working and whether it is the intervention or some other external, unaccounted for factor.

Learning from other areas

While we suggest that interventions should be designed within the scope of the MRC guidance, we also recommend that they draw on other approaches such as participatory action research. Participatory action research is a cyclical process of planning, taking action, observing, evaluating involving all interested parties. It is also worth thinking more laterally and look to be informed by a number of areas where 'harm reduction' work already exist. Harm reduction programs focus on making dangerous or risky behaviour safer by reducing the number of bad or negative outcomes. Examples include: Needle exchange programs for problematic drug users to reduce HIV, Hep C and other blood borne infections; school based sex education programs to reduce sexual risk behaviours and STDs; programs to reduce binge or problematic drinking; programs to reduce mental health stigma and programs to reduce knife crime.

Conclusion

The MRC guidance clearly sets out a robust, but ultimately lengthy process for proving an intervention or health program works. We know that the speed, growth and development of the social media landscape is fast paced. As the social media landscape evolves, we suggest perceptions of risk and acceptability do as well. More so, ideas such as, risk, safety, danger, vulnerability remain contextual and subjective. At their best, online safety programs need to accommodate this, while embracing a changing cultural and contextual mix. The pace of development and change along with contextual risk creates a tension when setting out to robustly evaluate a program. In reality, the MRC framework for complex interventions research approach is likely to take anywhere from three to five years to navigate. This does not include the additional time taken to publish research and for that to filter through to policy documentation and then implementation.

The realist review approach sets out with the aim of moving from understanding 'what works' to 'what works for who and why'. Approaches such as this, while offering more flexibility in evaluative approach still requires published research and policy documentation on which to base pragmatic policy or program implementation on.

The evolution of the Internet and social media landscape, particularly over the last ten years is well documented. While a large body of work suggests that the risks young people take through the process of identity formation, including sexual expression, problem solving etc. are largely unchanged (for example see Living and Learning with New Media), technology does create different methods of delivery and exposure. Therefore, one might argue that such research has a short shelf life. Those whose behavior was researched even as short a time period of five years ago will now be moving into adult life, and this emerging teenaged population will have been using the Internet from pre-school and will, arguably, have even greater confidence in the web and have even less distinction between their online and offline works.

Key to establishing whether online safety programs are effective is ensuring that they run within a robust evaluative framework. We suggest detailed application of the MRC guidance, or a full realist review are impractical due to intensive resource and time implications and far from practical in an everyday educational or public health environment. However, the need for acceptable evaluative models remains. Therefore we suggest the need for the systematic development of pragmatic evaluative guidelines for safe and appropriate use of the Internet by children and young people. It should be stressed, however, that if such guidelines are to be widely adopted, they need to be accessible. The online safety world is not exclusive within the academic or healthcare domain (both of which, one might argue) are evaluatively more rigorous than practice in other professions. If one does not wish to run the risk of "two tier" evaluation, such guidelines need to be understood by educational practitioners and civil servants as well as those with a stronger methodological training. We would argue that more "pilot" programs are needed in order to "prove" the value of rigorous evaluation is needed if a wider audience is to be reached.

About the Authors

Tobit Emmens is Head of Research Management and Innovation for Devon Partnership NHS Trust and a University Fellow at the Peninsula Medical School. He received his MSc (a meta-narrative review on suicide and media) from The Peninsula Medical School / University of Exeter in 2010. As a health services researcher, his research includes mixed-method approaches in both online and off-line settings, and include the investigation of patterns of ecstasy (MDMA) use in two English counties, the identification and management of suicide 'hotspots', the use of SMS Text Messages to support people who self-harm and the role of online communities for people who self-harm. Research interests include technology, social media, Internet safety, suicide and self-harm and how the Internet safety agenda relates to vulnerable young adults who self-harm and/or have other mental health problems. He has collaborative links with the Berkman Center for Internet and Society where he has contributed to the Youth and Media Policy Working Group Initiative. Prior to his NHS research role, Tobit worked as a support worker, naturopath and nutritionalist for people with problematic drug use (heroin, cocaine and crack) and with young offenders. Find out more: <http://pencentric.nhs.uk/about/people/tobit-emmens> and <http://twitter.com/tobite>

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About this Essay

This essay was written for the Risky Behaviors and Online Safety track of the Youth and Media Policy Working Group Initiative. The Initiative is part of Harvard University's Berkman Center for Internet and Society. The Initiative is exploring policy issues that fall within three substantive clusters that emerge from youth's information and communications technology (ICT) practices:

- Risky Behaviors and Online Safety
- Privacy, Publicity and Reputation
- Youth Created Content and Information Quality

The Initiative is funded by the MacArthur Foundation and is co-directed by danah boyd, Urs Gasser, and John Palfrey. The goal of the Initiative is to engage practitioners and make policy recommendations that are grounded in and connected to research findings. For more information:

<http://cyber.law.harvard.edu/research/digitalnatives/policy>

Bibliography

1. Byron T. The Byron Review. Nottingham: DCSF Publications; 2008.
2. Palfrey, J. boyd, d. Sacco, D. Final Report of the Internet Safety Technical Task Force of the Multi-State Working Group on Social Networking of State Attorneys General of the United States: Berkman Center for Internet and Society, Harvard University 2008.
3. UKCCIS. Children's online risks and safety: A review of the available evidence. 2010.
4. Dooley JJ, Cross, Donna, Hearn, <country-region>Lydia</country-region> and Treyvaud, Robyn. Review of existing Australian and international cyber-safety research. Perth: *Child Health Promotion Research Centre*, Edith Cowan University; 2009.
5. Charles C DS. Lay participation in health care decision making: a conceptual framework. *J Health Polit Policy Law*. 1993;18(4):881-904.
6. Health Do. Patient and Public Involvement in the NHS. London: Department of Health; 1999.
7. INVOLVE. Promoting public involvement in NHS, public health and social care research: Strategic Plan 2007 – 2011. National Institute for Health Research 2007.
8. Nilsen ES MH, Johansen M, Oliver S, Oxman AD. Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material. *Cochrane Database Syst Rev*. 2006;3:CD004563.
9. Oliver S MR, Bradburn J, et al. Involving consumers in a needs-led research programme: a pilot project. *Health Expect*. 2001;4(1):18-28.
10. Boote J TR, Cooper C. Consumer involvement in health research: a review and research agenda. *Health Policy*. 2002;61(2):213-36.
11. Oliver S C-JL, Rees R, et al. Involving consumers in research and development agenda setting for the NHS: developing an evidence-based approach. *Health Technol Assess*. 2004;8(15).
12. Staniszewska S JN, Newburn M, Marshall S. User involvement in the development of a research bid: barriers, enablers and impacts. *Health Expect*. 2007;10(2):173-83.
13. Trivedi P WT. From passive subjects to equal partners: qualitative review of user involvement in research. *Br J Psychiatry*. 2002;181:468-72.
14. Cowden S SG. The 'User': Friend, foe or fetish? A critical exploration of user involvement in health and social care. *Critical Social Policy*. 2007;27(1):5-23.
15. Crawford MJ RD, Manley C, et al. Systematic review of involving patients in the planning and development of health care. *BMJ*. 2002;325:1263.
16. Morgan A JD. Perceptions of service user and carer involvement in healthcare education and impact on students' knowledge and practice: a literature review. *Med Teach*. 2009;31(2):82-95.
17. Hardeman W SS, Griffin S, et al. A causal modelling approach to the development of theory-based behaviour change programmes for trial evaluation. *Health Educ Res*. 2005;20(6):676-87.
18. Ram MB GP, Weir H. Issues and challenges of involving users in medical device development. *Health Expect*. 2007;11:63-71.

19. Craig P DP, Macintyre S, Michie S, Nazareth I, Petticrew M. Developing and evaluating complex interventions: the new Medical Research Council guidance. *BMJ*. 2008;337:979-83.
20. Council MR. Developing and evaluating complex interventions: new guidance. In: Medical Research Council. 2008.
21. Biddle L, Donovan L, Sharp D. Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretative model of illness behaviour. *Sociology of Health & Illness*. 2007;29(7):983-1002.
22. Biddle L, Gunnell D, Sharp D, Donovan J. Factors influencing help seeking in mentally distressed young adults: a cross-sectional survey. *British Journal of General Practice*. 2004;54:248-53.
23. Boyd C, Francis, K., Aisbett, D., Newnham, K., Sewell, J., Dawes, G., & Nurse, S. Australian rural adolescents' experiences of accessing psychological help for a mental health problem. *Australian Journal of Rural Health*. 2007;15:196-200.
24. Nabors L AN, M, D. Weist, M, W. Reynolds, N, A. Tashman. C, Y, Jackson. Adolescent satisfaction with school based mental health services. *Journal of Child and Family Studies*. 1999;8(2):1062-24.
25. Murray CD and Fox J. Do internet self-harm discussion groups alleviate or exacerbate self-harming behavior? *Aus e-Journ for advancement of mental health*. 2006;5(3):1146-7984.
26. Thompson S. Suicide and the Internet. *Psychiatric Bulletin*. 2001;25:400.
27. Whitlock J, Powers J, Eckenrode J. The virtual cutting edge: The Internet and adolescent self-injury. *Dev Psychol*. 2006;42(3):407-17.
28. Adler PA, P. The Cyber Worlds of Self-Injurers: Deviant Communities, Relationships, and Selves. *Symbolic Interaction*. 2008;31(1):33-56.
29. Jones RS, J. Emmens, T. Sharkey, S. Hewis, E. Sheaves, B. Ford, T. Owens, C. Using metrics to describe the character of, and characters in, small discussion forums on self harm. In Press.
30. MHF. Mental Health Foundation report on the National Inquiry into Self-harm among Young People. London2006.
31. Gairin I HAOD. Attendance at the accident and emergency department in the year before suicide: retrospective study. *British Journal of Psychiatry*. 2003;183:28-33.
32. Owens D HJHA. Fatal and non-fatal repetition of self-harm. *British Journal of Psychiatry*. 2002;181:193-9.
33. Rodham K, Gavin, Jeff, and Miles, Meriel. I hear, I listen, and I care: A qualitative investigation into the function of a self-harm message board. *Suicide and Life-Threatening Behavior*. 2007;37(4):422-30.
34. Atkinson SFS, Phippen, AD. Using Peer-education to encourage safe online behaviour. LSE Eu Kids Online; London2009.
35. Eysenbach GP, J. Englesakis, R. Stern, A. Health related virtual communities and electronic support groups: systematic review of the effects of online peer to peer interactions. *BMJ*. 2004;328:1166-.
36. Powell J, A Lowe P Griffiths F & Thorogood M. A critical analysis of the literature on the Internet and consumer health information. *Journal of Telemedicine and Telecare*. 2005;11(Suppl 1):41-3.
37. Skinner A, Latchford G. Attitudes to counselling via the internet: A comparison between in person counselling clients and internet support group users. *Counselling and Psychotherapy Research [serial on the Internet]*. 2006; 6:

- Available from:
<http://www.ingentaconnect.com/content/routledg/rcpr/2006/00000006/00000003/art00002>.
38. Griffiths K CA, Banfield M & Tam A. Systematic Review on Internet Groups (ISGs) and Depression (2): What is Known About Depression ISGs? *Journal of Medical Internet Research*. 2009;11(3):e41.
 39. Friedemann M, Anderson KH. Family health care across cultures: An international online program. *Journal of Family Nursing* [serial on the Internet]. 2005; 11: Available from: http://www.find-health-articles.com/rec_pub_16287819-family-health-care-cultures-international-online-program.htm.
 40. Huband NT, D. *Understanding Repeated Self-Injury: A Multidisciplinary Approach*. Basingstoke, Hampshire, UK: Palgrave MacMillan; 2009.
 41. Jadad ARD, T. From electronic gadgets to better health: where is the knowledge? *BMJ*. 2003;327:300-1.
 42. Richardson G, Parry-Langdon N, Jacobson L, Donovan C. Bridging the gap: how do teenagers and primary health care providers view each other? *MCH* 19-10 Department of Public Health 2007.
 43. Skinner H, Biscope S, Poland B. Quality of internet access: Barrier behind internet use statistics. *Social Science & Medicine*. 2003;57(5):875-80.
 44. Whitlock J, Lader W, Conterio K. The Internet and self-injury: What psychotherapists should know. *Journal of Clinical Psychology: In Session*. 2007;63:1135-43.