**Promotion and views on tinnitus self-help within United Kingdom National Health Service audiology departments**

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**Abstract**

*Objective:* Self-help has the potential to provide low-cost and effective ways of improving access to psychological support for people with tinnitus. When developing and evaluating resources it is important to consider issues that may influence successful implementation. This Survey explored clinicians’ use and views on self-help, and barriers to implementation. *Design:*  An online survey was distributed to 220 UK audiology departments. *Study sample:* One-hundred and twenty-four clinicians responded to the survey (91 audiologists, 32 hearing therapists, one clinical psychologist), each representing a different tinnitus department. *Results:* Two-thirds of respondents reported providing or recommending self-help resources. Potential benefits were patient empowerment and providing a means of engaging patients in their care. Almost half of respondents felt that there is insufficient training or guidance for clinicians on using or promoting self-help. Clinicians felt that for patients with low-level tinnitus severity, self-help may reduce the number of audiology appointments required. For patients with more complex needs self-help may be useful to engage with between clinical appointments. *Conclusion****:*** Further research is needed to determine effectiveness, who benefits, and by what mechanism, before clinicians can confidently recommend or implement self-help. Clinicians will benefit from formal guidance on promoting and supporting use of self-help for tinnitus.

**Introduction**

Tinnitus is the perception of a sound without an external stimulus and can be associated with a complex set of symptoms that can negatively affect a person’s quality of life (Bartles 2008). Problems reported by tinnitus patients include fear, constant awareness, annoyance, or inability to concentrate (Watts et al. 2015). There is currently no universally effective management strategy for tinnitus although a number of approaches are recommended (Department of Health, 2009). These include self-help, management of hearing loss, sound therapies, and counselling or Cognitive Behavioural Therapy (CBT).

Self-help is defined as individuals working through therapeutic material either unguided or with minimal guidance from a therapist (Greenwell et al. 2016b). Self-help resources may be delivered using the internet, books and leaflets (bibliotherapy), CDs, computer packages, and applications (apps) for smart phones and tablets. A more structured programme of self-help may involve an individual working through a set of information using a variety of therapeutic resources, either on their own or with minimal guidance from a health professional.

Self-help resources for chronic conditions are associated with a number of general benefits, including increasing participants’ knowledge of their condition and symptom management (Barlow et al. 2002, Beatty and Lambert, 2013). Advantages of using self-help resources are that they can provide low-cost and easy access to psychological support, and provide an alternative for those unable or unwilling to attend traditional face-to-face services (Williams and Whitfield, 2001; Griffiths et al. 2006). They also reach a wide audience, allow people to work through materials at their own pace, and to revisit them on relapse.

For tinnitus, use of self-help materials is sometimes recommended within clinical protocols. For example, Progressive Audiology Tinnitus Management first described in (Henry et al. 2008a, 2008b) now includes the provision of *‘How to Manage Your Tinnitus A Step-by-Step Workbook’* by Henry et al. (2010a). This book, accompanied by videos and a sound demonstration CD, provides users with information about the causes of tinnitus, why it becomes a problem, and information on how to use sound to manage reactions to tinnitus. It also encourages users to develop their own action plans to self-manage reactions to tinnitus by using therapeutic sound and developing coping techniques. Effectiveness of using self-help materials alone or within such programmes has not yet been extensively studied.

Greenwell et al. (2016) identified only five studies assessing the effects of using self-help materials without clinical contact for tinnitus. Approaches included information leaflets, self-help books, and internet delivered self-help. Comparisons included waiting list controls, group therapy and therapist guided internet-based programmes. For example, three studies compared a self-help programme to a passive control (waiting list or basic information leaflet). Of these three studies, only one found that tinnitus distress was significantly lower post programme in the internet self-help programme group (but not their self-help book group). All five studies included in the review were rated by the authors as being low to moderate quality, limiting confidence in the estimated effects. Nyenhuis et al. (2013) additionally reviewed minimal contact CBT-based self-help programmes and found them to have a moderate effect on tinnitus distress and generalised depression compared to a passive control, indicating that the self-help programmes were efficacious in reducing psychological distress. The authors reported that when comparing CBT-based self-help with face-to-face CBT the level of tinnitus distress and depressiveness did not differ post-programme, indicating that self-help programmes with little or no therapist contact can be as effective as face-to face therapy. The authors suggested caution in interpreting these results due to limitations in the design of the included studies. Rather, face-to-face CBT is the only tinnitus intervention with a convincing body of randomised controlled trials demonstrating effectiveness in reducing tinnitus distress. On that basis, psychologists, and audiologists alike, may be resistant to the use of self-help interventions in the place of face-to-face therapy. The materials used may be the same, but the ability to establish a therapeutic relationship between clinician and patient may or may not be (Clarke et al. 2016, Ormrod et al. 2010*)*A recent Delphi study from Thompson et al. (2018) indicates how important both patients and clinicians consider the use of common therapeutic skills in tinnitus management to be. Socratic questioning, active listening (e.g. verbally restating the patient’s statements, eye contact, body posture), verbal encouragement, demonstration of sincerity, sympathy, and empathy, were all judged to be essential to important to positive outcomes for patients.

As well as evidence of effectiveness, clinician attitudes towards self-help interventions influence what is recommended and used by patients. For example, concerns exist around training and evidence of effectiveness of computer-based CBT for adults with mental health disorders (Whitfield and Williams 2004), and children and adolescents with emotional disorders (Stallard et al. 2010). Of most concern in those studies was the impact that the lack of a therapeutic relationship had on the patient, the inflexibility of online CBT to meet individual patient needs, and the likelihood of poor compliance with an online intervention. Clinicians felt that computerised CBT should not be provided without professional support and face-to-face contact. The main advantages of self-help programmes identified in those studies were that patients could use the intervention at home, that they reduce stigma about the relevant health condition, and that they provide rapid and 24 hour access to treatment.

In the light of mixed evidence for effectiveness, and no previous study exploring audiology clinicians’ usage and attitudes towards self-help resources for tinnitus, we surveyed clinicians on what they understood and believed about these resources and how they use them and what they feel are potential barriers preventing the implementation of self-help resources or of more structured programmes of self-help.

**Methods**

This study was a service evaluation of tinnitus care in UK National Health Service audiology department. These services largely employ audiologists (proving hearing rehabilitation and sound therapy, with some also trained in CBT or counselling). Some services also employ hearing therapists (more emphasis on counselling), and a small number have access to a clinical psychologist (Gander et al. 2011).

Data were analysed with the support and permission of the data controller (DS). This use of the data complies with the governance procedures of the charity. As this study was a service evaluation and used only anonymised data for the purpose of service evaluation, individual consent was not sought, and research ethics committee review was not required (Health Research Authority 2017)

**Survey development**

A set of questions relating to clinician awareness of and opinions on self-help resources (Appendix 1) were developed by KG and DJH. Questions were reviewed for face validity by two audiologists and included in the British Tinnitus Association (BTA) 2015 service evaluation. Routine questions asked in the service evaluation can be reviewed in Hoare et al. (2015).

**Survey administration**

The survey was administered online using SurveyMonkey (surveymonkey.com) from August 2015 until January 2016. A link to the survey was emailed to all contacts registered on the BTA database of UK-based audiologists and National Health Service (NHS) audiology departments and advertised by professional bodies. Sampling was representative in that only one response was accepted from each NHS audiology department, and that response was taken as representative of the department. As such limited personal data about the respondents was collected, they were all qualified clinicians. Responses to each question were optional.

**Closed Questions**

The survey provided five examples of self-help resources and asked participants to select those they were aware of, there was also an open response available for this question allowing respondents to list any other self-help responses used by the department. Respondents were then asked about how self-help materials are currently used for tinnitus in their department with the response options: (1) We provide or recommend self-help resources and provide additional guidance from a clinician to use them; (2) We provide or recommend self-help resources but DO NOT provide additional guidance from a clinician to use them; and (3) We don't provide self-help resources or recommendation. We also asked, “If you provide or recommend self-help resources or programmes, please tell us which, and tell us how you use them”.

Respondents were asked about any barriers or reasons not to deliver self-help programmes in tinnitus services with the closed response options: (1) Self-help programmes are not necessary as most tinnitus services have adequate access to psychological services; (2) There is insufficient evidence that self-help programmes are effective; (3) There is insufficient training or guidance for clinicians on delivering self-help programmes; (4) There is not enough time during clinic appointments to address self-help programmes; (5) There is insufficient funding or resources for delivering self-help programmes; (6) There is a lack of knowledge regarding the most appropriate self-help materials to recommend; (7) Patients do not want to use self-help materials/programmes; (8) Self-help programmes work best when patients identify and work with their own self-help materials, outside of a medical setting; and (9) ‘Other’ which was an open response option allowing respondents to add barriers or reasons they were aware of which were not listed in the response options, the responses to the ‘other’ option were limited and were summarised and reported in the narrative.

**Open Questions**

We also asked the following open questions: “Which patients benefit from using self-help programmes?”, “Which patients should not use self-help programmes?”, and “Can you describe any perceived benefits of providing self-help programmes, for your patients or your service?”

**Analysis**

Responses to the closed questions were quantitatively analysed and presented as the number and percentage of complete data responses for that question. Responses to the three open questions were analysed individually for each question using thematic analysis (Braun and Clarke, 2006), and independently coded by SS, EW, and DH. Agreement on the codes was then reached through consensus and discussion. Codes were grouped by SS and DH to develop themes. These themes were reviewed by KG as a further iteration before final themes were agreed. Participant quotes are used to illustrate the themes.

**Results**

One hundred and twenty four clinicians responded to the survey including 91 audiologists, 32 hearing therapists, and one clinical psychologist, each representing the views of a different NHS tinnitus service. The Audiology services that responded indicated that the departments involved in the tinnitus service consisted of Audiology (100%) ENT (51%) and Clinical Psychology (11%). Some respondents did not complete every question. Responses were received from an estimated 56% of NHS departments

**Closed questions**

**Awareness of self-help materials and programmes**

Almost all respondents were aware of the book ‘Living with Tinnitus and Hyperacusis’ (n = 108, 98%). Fewer were aware of the ‘Tinnitus E-Programme’ (n=40, 36%), the NHS ‘Moodzone’ website (n = 33, 30%), the ‘Moodjuice’ website (n=26, 24%), or the ‘overcoming’ book series (n=22, 20%). Other resources respondents were aware of included ‘Living life to the full’, an online and telephone CBT resource for mental and physical wellbeing (<http://www.llttf.com>) (n=4, 3.6%), the BTA website (http://www.tinnitus.org.uk), the CBT website ‘Get self-help’ (https://www.getselfhelp.co.uk) (n=3, 3.2%). And the Expert Patients Programme (EPP) (https://www.gov.uk/government/case-studies/the-expert-patients-programme) (n=2, 1.8%) Other resources mentioned by single respondents included Moodcafe beating the blues’ (<http://www.moodcafe.co.uk/free-online-behavioural-therapy.aspx>), ‘Mindfulness’ a practical guide to peace in a frantic world’ (William and Penman, 2011), the ‘Sleepio’ programme ([https://www.sleepio.com](https://www.sleepio.com/)), the ‘Mind over Mood’ book (Greenberger and Padesky,1995), or referred to an education programme but did not provide details.

**How clinicians use self-help materials for tinnitus**

Forty respondents (35%) reported that they provide or recommend self-help materials and provide additional guidance on using them. Thirty-eight respondents (33%) reported that they provide or recommend self-help materials, but do not provide additional guidance on using them. Thirty-six responders (32%) reported that they do not provide self-help materials or recommendations.

Specifically mentioned were BTA leaflets for adult patients, or directing patients to the BTA website (n=48, 40%). One respondent mentioned providing patients with the BTA paediatric leaflets. Action on Hearing Loss resources were also mentioned (n=4.3, 5%). Eleven respondents (9.7%) mentioned relaxation classes or techniques with most informing patients about local classes, and a subset of respondents providing classes or specific exercises. One respondent reported that their department had devised an in-house programme for patients to use but no further information was provided. Seven respondents mentioned CBT, either as an internet-delivered or telephone resource (6.1%). Six respondents (5.2%) mentioned that they recommended tinnitus, sleep, or mindfulness apps (no specific apps were identified), and one respondent indicated that they also demonstrated how to use the apps. Five respondents indicated that they recommended CDs for sound enrichment or relaxation (4.4%). The only CD identified was ‘Steps for Stress’ (http://www.stepsforstress.org/templates/Inner/order-cd.php). Two respondents said they recommended the ‘Tinnitus-E-Programme’, one of whom signified that it was recommended to motivated patients only.

**Reasons offered for not promoting Self-Help**

Participants were asked about any reasons they would not support the delivery of self-help materials or programmes in their tinnitus services, with 88 responses. The main reasons identified were clinician concerns about training and guidance on how to deliver self-help, and which are the most appropriate types of self-help materials to recommend to patients (Figure 1). Only one person felt that self-help materials were not needed because tinnitus services have adequate access to psychological services. ‘Other’ barriers identified were the level of patient motivation, lack of provision of self-help for children with tinnitus, poor access to computers, and low levels of computer literacy.

**Insert Figure 1 about here xxx**

**Open questions**

The thematic analysis of the three open questions identified two themes, which are described below and in Table 1.

**Descriptions of who will benefit most from self-help**

Four sub-themes relating to which patients clinicians believe will benefit most from self-help emerged.

Table 1. Outline of themes, sub-themes, example quotes, and frequency of responses for the qualitative survey data

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| --- | --- | --- | --- |
| **Theme** | **Sub-Themes** | **Example Quotes** | **Frequency of responses\*** |
| **Descriptions of who will benefit most from self-help** | Motivation and acceptance | *“Those who have some motivation towards managing their tinnitus and have reached an acceptance of their situation.”(R92 Senior Audiologist)* | 63 |
| *“There are a few patients who still regard tinnitus as a 'fixable' illness which we should cure and are inflexible when it comes to following or using self-help.” (R79 Specialist Hearing Therapist)* |
| Tinnitus severity and comorbidity | *“Usually patients who are not overly distressed with the condition, and don't have additional mental distress.” (R50 Hearing Therapist)* | 48 |
| *“Patients with tinnitus related distress persisting after information group and hearing aid fittings.” (R113 Hearing Therapist)* |
| *“Unsuitable for those who are suffering from severe distress from their tinnitus and need more personable support with managing it.” (R67 Advanced Specialist Audiologist)* |
| Preference for and ability to access digital interventions | *“[People] who like using computers or mobile phone devices.” (R118 Deputy Head of Audiology)* | 12 |
| *“[Patients] with access to the internet.” (R10 Hearing Therapist)* |
| Ability to understand | *“Those receptive to the psychological theories of tinnitus.” (R52 Specialist Audiologist)* | 17 |
| *“Those with individual barriers to this [self-help] such as partially sighted, learning disabilities, dyslexia, language barriers [would not benefit].” (R33 Specialised Hearing Therapist)* |
| **Benefits of providing self-help programmes** | Patient empowerment | *“Self-help programmes might empower patients to take responsibility for the management of their conditions.” (R52 Specialist Audiologist)* | 33 |
| *“Patients appreciate taking control for themselves over health issues and feel better equipped to deal with them presently and in the future.” (R46 Audiologist and Hearing Therapist)* |
| More efficient and cost-effective service | *“Self-help is a very good way of improving the patient’s outcome. It may also save the department money and time.” (R15 Senior Audiologist)* | 21 |
| *“Self-help can reduce appointments required, therefore reducing waiting times.” (R20 Chief Audiologist)* |
| Improved accessibility of the resources | *“Quick and easy access to information and reassurance.” (R108 Clinical Lead Audiology)* | 17 |
| Enhanced patient experience | “*Often there is a lot covered in appointments, so it is beneficial that patients take information home and they have the chance to go over it and reflect. Patients also feel reassured that they have self-help material.” (R56 Senior Audiologist)* | 20 |

Key: \* = This is the number of participants with data coded at each sub-theme

(1) Motivation and acceptance: This was a dominant sub-theme, with respondents describing patients wanting to take control and responsibility for their care. Motivation also incorporated patient readiness to take control, the time being right for the patient, openness to engage with self-help, and understanding the limitations of self-help. Many clinicians felt that the patients who are likely to benefit from self-help are motivated to take control or responsibility for their own care, are willing to commit the time and effort required to self-help, and have accepted their tinnitus:

*“Patients willing to put extra effort and able to manage themselves”.* (*R78*, Senior Audiologist)

*“Patients who are keen to change behaviour”.* (*R114*, Senior Audiologist/Hearing Therapist)

*“Patients who are motivated to work through them [the self-help materials]”.* (*R22,* Hearing Therapist)

*“Patients who have an open mind and are accepting of the fact that we can't cure tinnitus but can learn management techniques to help facilitate habituation.” (R24,* *Hearing Therapist).*

Respondents felt that other patient groups may not benefit from self-help programmes such as.

*“Patients in the acute phase who need educating and reassuring first before they can access self-help”. (R45, Chief Hearing Therapist)*

*“Those that just [go] from 'cure' to 'cure', and get discouraged everytime when they don’t work. Feel they would initially need more guidance on expectations and what it means to manage their tinnitus”. (R68, Senior Audiologist)*

*“I would not think it appropriate for patients who are lonely and isolated without guidance and support”. (R89, Audiology Services Manager)*

(2) Tinnitus severity and comorbidity: Many respondents felt that self-help programmes were more suitable for *“Patients with mild to moderate level of tinnitus awareness”.* (R106, Clinical Lead Audiology), and *“Patients who are not overly distressed with the condition, and don't have additional mental distress”. (R48, Hearing Therapist).*

A small number of respondents feltthatpatients with more complex needs such as those with *“tinnitus-related distress [that is] persisting after information group and hearing aid fittings”,* or those who were anxious, depressed or had other co-morbidities may benefit from the extra support of self-help programmes between clinical appointments. Clinicians indicated *“Patients with other mental health problems seeing other mental health practitioners”.* (*R101*, Audiologist) were a contra-indication to self-help. Other respondents described patients requiring *“emotional support”*, being *“vulnerable”*, or having anxiety, depression, or high levels of tinnitus distress as being unsuitable for self-help programmes.

(3) Preference for and ability to access digital interventions: Respondents indicated that patients who had time constraints or other difficulties attending clinics and were computer literate would benefit from using self-help interventions.

*“Patients whom don’t like to attend a support group but are interested in getting more training”, also some patients can’t commit their time to CBT training due to work commitments”. (R69, Senior Audiologist)*

*“Patients who find it difficult to come to appointments. Young working age patients”. (R84 Chief Audiologist)*

(4) Ability to understand: Respondent comments under this sub-theme centred on a patient’s ability to understand the concept of self-help, such as:

*“Those who have a clear understanding of the purpose [of self-help] and their own expectations”. (R63 hearing therapist)*

*“Patients who understand that they can help themselves”. (R113 Audiologist)*

Respondents felt that other patient groups may not benefit such as those patients with learning difficulties, patients with language difficulties or poor levels of literacy, and patients who were partially sighted:

*“Those with individual barriers to this such as partially sighted, learning disabilities, dyslexia, language barriers or visual vertigo also those requiring individual sessions due to more significant problems”. (R29, hearing therapist)*

**Benefits of providing self-help programmes**

Most respondents indicated that self-help resources might empower patients and make them more confident about managing their tinnitus. A large number of respondents indicated that self-help could make their service more efficient and cost-effective, e.g. by reducing the number of appointments a patient may require. Many respondents cited improved accessibility of the resources as a potential benefit, e.g. the ability to log on to a website or read information outside clinic hours. Respondents were also of the opinion that the provision of self-help by a clinic may enhance the patient experience and act as an adjunct to usual clinical services giving the patient something to draw on between clinical appointments:

*“Faster access to self-help material for Pt [patient] and more economical use of clinic time”. (R33, Senior Audiologist)*

*“Often there is a lot covered in appointments, so it is beneficial that patients take information home and they have the chance to go over it and reflect. Patients also feel reassured that they have self-help material”. (R54, Senior Audiologist)*

**Discussion**

For nationally funded health services with finite resources self-help resources and programmes have the potential to provide low-cost and effective ways of improving access to psychological support for people with tinnitus. However, for the success of any health interventions, it is important to consider issues that may influence uptake and implementation. In the current study, we asked clinicians to describe their use and views on self-help materials for tinnitus, and to describe any potential barriers they perceive to uptake and implementation. Responses were received from 56% of NHS departments, primarily from audiologists, so although not complete was representative of tinnitus care in the UK. The main limitation of the study was the broad nature of questions used. Another limitation is that the survey data does not allow for issues to be explored in-depth, qualitative research would allow a more in-depth exploration of the barriers and concerns of clinicians

Respondents were aware of many different forms of self-help and most indicated that they recommend or provide resources to their patients either with some guidance or without guidance. For example, some respondents indicated that they recommended or provide relaxation training. If delivered by clinicians then relaxation classes are not by definition ‘self-help’ as they do not replace a face-to face service. However, the use of learned relaxation techniques (e.g. using books or CDs) in daily life would constitute self-help. In this study we provided participants a definition of self-help with examples of self-help interventions. The results generated suggest some blurring or what is thought of as ‘self-help’ by clinicians with respect to our working definition. What we can interpret therefore from responses to some of the broader questions in this study (e.g. that 35% of the participants use self-help materials) is limited and should be further differentiated. Some respondents indicated that they do not provide any form of self-help resource, citing a lack of guidance on how best to deliver self-help resources or programmes together with a lack of knowledge about which are of acceptable quality and effective. Interestingly, some respondents who do provide self-help resources also noted the lack of guidance. Anecdotally, in the UK at least, there is limited reference to self-help groups, relaxation techniques, sleep hygiene, mindfulness, or internet based information included in audiologist training programmes. Currently, there is no British Society of Audiology guidance for tinnitus in adults, although one is now in development (Hoare, 2017), giving the opportunity to introduce national guidance about self-help and for it to be incorporated into the audiology curriculum.

Existing guidelines in other countries already do make recommendations. Tunkel et al. (2014) states that clinicians should educate patients by providing brochures and self-help books, and recommends brochures available from the American Tinnitus Association and other organisations. Self-help books are also recommended in that guideline including ‘Tinnitus a Self-Management Guide for the Ringing in Your Ears’ (Henry and Wilson, 2001). Similarly, in the Netherlands educational material about tinnitus is considered essential, and in Sweden tinnitus information provided either individually to a patient or via group meetings are recommended (see Fuller et al., 2017 for a review).

Clinicians may be unsure of which self-help resources are most appropriate for a given patient, and this may be part of the reason why some clinicians do not make specific recommendations. There is however a growing body evidence that internet-based CBT may provide an effective, accessible, and low cost intervention for many chronic health conditions. The number of studies that have looked at self-help specifically for tinnitus is growing. Historically, the quality of the studies tends to low to moderate. (Nyenhuis et al. 2013; Greenwell et al. 2016). Since then, patient’s views on the Tinnitus-E-Programme have been studied; Greenwell et al. (2016a) carried out a process evaluation to explore user’s reactions to, and interactions with the programme. In a randomised controlled trial Beukes et al. (2018) demonstrated that internet-based CBT (guided by an audiologist with supervision by a clinical psychologist) significantly reduced tinnitus distress. A search of Clinicaltrials.gov indicates that there are three studies (NCT01205919, NCT01205906, NCT01927991), investigating self-help programmes based on CBT, but no results from these studies have been published to date.

With the growing prevalence of smartphones and tablets there are now a variety of apps which are available to patients. A small number of respondents indicated that they provided patients with information about apps with some respondents indicating that they recommended (unspecified) tinnitus, sleep, or mindfulness apps. In a recent survey of people with tinnitus Sereda (2017) indicated that most people who do not use apps to manage their tinnitus are actually unaware of them. Guidance on the use of apps and a quality standard would help clinician’s signpost patients towards apps which are of a higher quality and most appropriate to individual need.

Potential barriers to self-help highlighted were a lack of provision for patients where English is a second language, those with poor literacy, or those who are partially sighted. There were mixed views on tinnitus severity as a barrier. The main facilitator appeared to be readiness, openness and motivation to engage in self-help. As such, clinicians need to be able to assess a patient’s readiness to engage to ascertain if self-help would be a viable option. There is no widely used method for measuring how ready a tinnitus patient is to engage with self-help. Although not specific for tinnitus The Patient Activation Measure (PAM) developed by Hibbard et al. (2004) has been used in other chronic health conditions and its use is supported by the NHS (<https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-faqs/#13>). The PAM identifies four stages of patient activation. Assessing its use with tinnitus patients may be a future avenue of research.

Where the patient is considered ready then clinicians should recommend or advocate self-help resources and at the same time make them easy to use and convenient to the patient. Clinicians need to be aware of and explore what is available for example BTA information leaflets are available in easy read, large print, and audio format. Action on Hearing Loss also offer factsheets in large print, Braille, and audio format. The ‘Steps for Stress’ booklet and some online resources are also available in popular languages including Cantonese, Polish, and Urdu. (<http://www.stepsforstress.org/templates/Inner/order-booklet.php>). Where there are real gaps in provision clinicians should make providers aware of them.

Lack of access to a computer and/or the internet was also identified as a potential barrier to the uptake of self-help. However the percentage of the UK population who are weekly users of the internet has risen from 57% in 2006 to 93% in 2016 in the 16 to 74 year age group and from 33% to 81 % in the 55-74 year age group (United Economic Commission for Europe, statistical database) indicating that this is becoming less of a barrier. When developing new digital self-help interventions care must be taken to ensure they are easy to use and have been tested by their target populations to ensure they are suitable for those who have a low level of computer literacy. However continuing to ensure that self-help resources are available in a variety of formats (paper-based, audio, online), and that they are sufficiently usable (e.g. by those with low computer literacy) is clearly important in providing patients with choice.

**Conclusions**

Respondents in this service evaluation recognise the potential for self-help resources and programmes to play a useful role in tinnitus management. For patients with low level tinnitus severity (e.g. requiring education only) they may reduce the number of audiology appointments that are needed, freeing up greater resource for those with greater need for psychological support. For patients with more complex needs self-help programmes may be useful to engage with between clinic appointments. Before clinicians can confidently recommend or implement self-help resources and programmes as part of their practice they need to be sufficiently evaluated using recognised evaluation techniques to provide evidence of effectiveness and to determine who benefits and how. Clinicians would also benefit from receiving guidance on how to introduce self-help programmes to patients. Clinicians should make researchers and professional bodies aware which self-help topics they feel require further research and guidance.

As this survey was a service evaluation it is assumed that the responses obtained from the respondent represented the views of the department and therefore reflects current practice. Very little demographic data was collected and this may be seen as a limitation. The survey questions were broad in nature and the authors acknowledge this as a potential limitation. We consider the results and any conclusion as a starting point to further research around the topic of how self-help for tinnitus patients could be developed and implemented within the context of current healthcare provision.

**Declaration of Interest.**

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**Figure legend**

**Figure 1:** Reasons offered by clinicians for not promoting Self-Help

**Appendix 1:** List of survey questions relating to self-help