



Remote mental health interventions for young people

A rapid review of the evidence

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Executive summary

The Covid-19 pandemic has been a huge challenge for services, but also an opportunity for reflection and change. As social distancing measures are lifted mental health services will begin to re-introduce face-to-face support, and many will be making decisions about how to embed and expand elements of what worked well during the pandemic. By setting out the findings of a rapid review of current research into remote interventions to support young people's mental health, this briefing supports evidence-informed decision-making in policy and practice during this new period of transition.

Aims and focus

Our aim was to summarise current evidence of the impact and implementation of remote interventions to support young people's mental health. Remote interventions include any form of support that is not delivered in person (e.g. telephone or video calls, online chat messaging or forums, text messages or emails). To make sure we were generating knowledge that was most useful for our member organisations we only included remote support that was delivered by a counsellor, or other practitioner, meaning this review does not cover app-based or computerized interventions

Key findings

Characteristics of the studies and interventions included in the review

Fifty studies were included in the review, most were qualitative (e.g. focus group or case studies), or small survey studies, meaning that the data has limitations, especially in terms of its representativeness and generalisability.

Most studies were conducted within community based mental health services which were delivering counselling support via online chat or videocall. There was some evidence that young people accessing remote services were experiencing very high levels of psychological distress and complex life challenges.

Outcomes of remote mental health interventions

Very few studies conducted a rigorous evaluation of remote interventions, however initial findings suggest these forms of support can lead to positive outcomes amongst young people, including reductions in the severity of clinical symptoms, increased wellbeing, and lower levels of suicidality and stigma.

Acceptability amongst staff and young people

Survey studies found that most young people were interested in trying remote mental health support, however the majority of those attending face-to-face sessions were not comfortable with it being used as a replacement for these services. Most young people accessing online chat or telephone support reported high levels of satisfaction and said their preference was to receive support in this way rather than face-to-face.

Studies in which young people did not have a choice about whether or not they accessed remote support (e.g. when they were randomly selected to receive remote support), reported low engagement and very high dropout rates, however where it was the young person's choice to access this type of support dropout rates were much lower.

Many studies reported high levels of resistance to adopting remote support amongst practitioners, even when young people had expressed a preference for these interventions, or when services had trialled them with positive outcomes. However, some of these findings may be out of date as many more practitioners now have experience of working remotely. Factors influencing acceptability of remote support amongst practitioners included their age, experience of using technology in their daily life, attitudes towards technology (e.g. the internet), and values and beliefs about their professional role and responsibilities. Most studies conducted in services which were delivering forms of remote support reported high levels of satisfaction amongst clinicians, however one found that clinicians limited the use of this service, despite it being popular amongst young people.

Organisational barriers to implementation

Many studies found that practitioners often felt under resourced and under prepared to implement remote interventions, including concerns about a lack of skills and training and clear policies and procedures, limited access to equipment and resources and a lack of time. This may have changed during the pandemic as a number of resources (e.g. around safeguarding) have now been developed to support practitioners working in this way.

Accessibility

A number of studies concluded that remote interventions were an effective way of supporting young people who find it difficult to access face-to-face counselling including young men, young carers, young people with disabili-

ties or those living in remote locations and young people experiencing life problems which might be associated with strong feelings of stigma or shame (such as challenges linked to their gender identity or sexuality). Some young people and practitioners felt remote services were more flexible and accessible compared with face-to-face counselling, because:

- Support was available outside of office hours;
- Young people generally had a shorter wait to access remote support and less time to wait between sessions;
- Young people did not have to rely on parents or carers for transport;
- Young people had to take less time out from work or school to attend appointments;
- Support could be accessed while young people were at home, in a comfortable and familiar environment.

However, studies of 'drop-in' online chat services found that young people would often have to wait in an online queuing system for several hours before speaking with a counsellor and that there was no guarantee they would be able to access support before the service's closing time. There were also limits around how responsive remote services could be in 'real time', especially when communication was by email or text. Issues with technology could disrupt access (e.g. due to problems with the sound or video quality of a call). There were also concerns that remote support would not be accessible to young people who did not have access to a computer or phone, or the internet.

Emotional safety and stigma

Young people accessing remote interventions said these services felt safer than in-person support, which meant they felt more able and willing to discuss their experiences within these contexts. They chose to engage with remote support to minimize the risk of being judged, or experiencing other challenging reactions such as misgendering or feelings of stigma. Some young people found the prospect of 1:1 support overwhelming, scary, and uncomfortable so wanted to minimize social or verbal interaction with a therapist.

Confidentiality and privacy

Practitioners and young people felt there were inherent risks to privacy associated with text based interventions such as email or web chat, which raised ethical and legal concerns for staff around consent, confidentiality, and if and how to store records of conversations. Despite this in a number of studies young people expressed a preference for text-based support over phone or face-to-face counselling because they felt it was more private.

The therapeutic relationship

Studies with practitioners working within remote services found it was possible to develop strong therapeutic relationships within these contexts, however noted that this was more difficult, and often took more time than when meeting with the young person face-to-face. Most remote support was time limited and described as 'brief', and there was a sense that although valuable, remote interventions were often not long enough, both in terms of the number and length of individual sessions. One study found that therapists were often unable to progress to the later (more impactful) goal planning stages of the therapeutic process as young people disengaged after just a few sessions. This was particularly an issue for text-based interventions, where the pace of communication was much slower than talking in person.

Themes of power and control were prevalent in the literature and central to the experiences of both young people and practitioners. Remote interventions were seen to challenge traditional dynamics within the therapeutic relationship, by shifting power from the practitioner to the young person, and many young people said they chose to access remote support because it gave them more control over their personal information and the therapeutic process. Accounts from practitioners revealed feelings of vulnerability and discomfort about being out of control, e.g. when they could not 'see' what a young person was doing, or access information about them.

Safety and safeguarding

Risk management was identified as a major concern in many studies. Practitioners often supported young people who disclosed self-harming behaviours, suicidal thoughts, and sexual abuse remotely and had to find ways of coping with feelings of helplessness and fear when they were not able to take action to protect a young person. Practitioners also described having a limited understanding of the legal and ethical issues around confidentiality and data management in relation to remote support. Studies concluded that those managing and supporting teams offering remote interventions should have an understanding of the unique challenges that can be experienced when communicating with young people in this way, and that spaces should be provided where therapists can discuss these issues.

Challenges and adaptations when communicating remotely

A common theme across many studies was the unique challenges encountered when communicating remotely, including:

- Delays or disruption to communication due to poor signal;
- Poor signal causing the session to end prematurely;
- Disruption due to background noise;

- Loss of non-verbal communication and eye contact;
- Loss of control because the young person could end the session at any time, without warning;
- Difficulties recognising and using therapeutic tools and processes such as transference, countertransference and silence;
- Increased possibility of miscommunication, or misinterpretation when communicating via text;
- Concerns that young people would not be giving the session their full attention (e.g. because they could be visiting websites, etc whilst online);
- Difficulties judging a young person's literacy level when communicating via text;
- Managing boundaries when offering support via webchat (so communication did not become inappropriate or overly familiar).

Practitioners made the following adaptations to facilitate the therapeutic process within these contexts:

- Slowing down the pace of communication and pausing before responding;
- Deliberately exaggerating non-verbal behaviours;
- Asking young people about their non-verbal behaviour to ensure they were interpreting it correctly;
- Introducing the most significant issues early on in the session, or planning shorter video sessions followed up with a phone call;
- Focussing on the tone and intensity of the young person's voice;
- Mirroring the language used by young people;
- Using simple language when communicating via text;
- Setting a time limit for webchat sessions;
- Using an informal and open style of text communication, including emoticons, acronyms, slang, nicknames (e.g. "kiddo"), capital letters, and virtual hugs.

Conclusions

There were very few robust evaluations of remote support, however those included in our review suggest it can lead to improvements in young people's mental health and wellbeing.

There were examples of how these interventions can allow services to work flexibly and adapt their ways of communication to fit the needs of the young person. In this sense remote interventions, when offered alongside face-to-face support, can help to build a service that is truly young person-centred.

However our findings suggest that using remote interven-

tions as a replacement for face-to-face support (as was necessary during the Covid-19 pandemic) is problematic.

Remote interventions were typically described as 'brief', meaning sessions were largely focused on providing space for the young person to tell their story and practitioners often did not have time to identify action plans or goals. It may be useful for services to consider how their approach could be adapted to provide the most impact over a small number of sessions. Some training around how practitioners can increase engagement might also be useful.

Remote support requires staff to re-think their ways of working and identity. This may be less of an issue following the pandemic, however, could still be a challenge for newly qualified practitioners, or those who were furloughed. There was also evidence that staff can remain resistant to providing remote support in services that had adopted these approaches, even when they worked well and were popular amongst young people. In these cases training around the strengths of remote support, and the experiences of young people may be helpful. This should also be included in undergraduate and entry level training for mental health practitioners.

Introduction and purpose of review

The social distancing measures introduced in response to the Covid-19 pandemic have had a profound impact on the ways in which young people can access and engage with mental health support. Services have had to rapidly adapt how they deliver interventions in response to this crisis, many moving online, or using phone, videocalls and text messaging to reach out to young people (Jack Martin et al. 2020). We have seen how voluntary sector services, such as Youth Access members, in particular, have been able to respond quickly and innovatively to the changing circumstances: developing and implementing new ways of working, led by young people's needs, to support their mental health (you can read more about some of these initiatives here: <https://www.youthaccess.org.uk/case-studies/what-are-other-organisations-doing>)

The pandemic has been a huge challenge for services, but also an opportunity for reflection and change. As social distancing measures are lifted, mental health services will begin to re-introduce face-to-face support, and many will be making decisions about how to embed and expand elements of what has worked well during the pandemic. This briefing sets out the findings of a rapid review by Youth Access of current research into remote interventions to support young people's mental health. We hope this will support evidence-informed decision making in policy and practice across Youth Access and our member organisations during this time.

Review methods

A rapid review is a form of knowledge synthesis that follows the processes of a systematic review, but where parts of the review are simplified or omitted so that evidence can be reviewed quickly. The aim of this review was to summarise current evidence of the impact and implementation of remote interventions to support young people's mental health. Remote interventions include any form of support that is not delivered in person (e.g. telephone or video calls, online chat messaging or forums, text messages or emails). To make sure we were generating knowledge that was most useful for our member organisations we only included remote support that was delivered by a counsellor, or other practitioner (e.g. psychiatrist, psychologist, youth worker), meaning this review does not include app-based or computerized interventions, or forms of peer support (for example online forums such as Elefriends; <https://www.elfriends.org.uk/>).

The following criteria were used to decide whether or not to include a piece of research in this review; we only included studies which were: i) original research or case studies (i.e not a review or opinion piece), ii) on remote mental health interventions, iv) for young people (aged 11-25), vi) published in English vi) about approaches which could feasibly be implemented by our members at low cost and in a timely manner during the pandemic

(e.g. we excluded studies of app-based or digital interventions which would either require a significant level of programming or development, or where organisations would need to purchase an expensive package of software).

We carried out online searches of electronic databases and Google using key search terms (see Appendix for more details about our search strategy). We also contacted partner organisations and experts in youth counselling and asked them to identify any relevant information. Abstracts and report summaries were screened for relevance according to the criteria listed above. Data from material meeting these criteria were copied into an Excel database, and coded into the following categories; type and description of intervention, participants, age of young people, methods, setting, country, outcomes data, perspectives and experiences of young people and families, perspectives and experiences of staff, lessons for implementation, safeguarding and costs. We then conducted a thematic analysis of data within each of these categories (Braun and Clarke 2006), and our findings in relation to each theme are presented below.

Results

Type and quality of studies

Key findings: Fifty studies were included in the review, most were qualitative (e.g. focus group or case studies), or small survey studies, which means there are limitations in terms of the representativeness of these data.

We identified fifty studies that met the criteria for inclusion in the review, the majority of which were conducted in the USA (n=12), followed by Australia (n=10), Canada (n=5), the UK (n=6), the Netherlands (n=3), and Greece, Ireland, Israel, and New Zealand (n=1 respectively).

Most studies were qualitative, including case studies of young people, and services (n=14), focus group and interview studies (n=3), and qualitative analysis of the content of counselling sessions (n=2). These studies provide in-depth accounts of the experiences of young people, and staff, but involve small samples and so these data are not representative of a population, and do not provide strong evidence about the outcomes of an intervention. Other studies included cross sectional survey studies (n=11), which mostly took place within a single service. Sample sizes were on average between 100-200 participants, meaning there are also limitations with the representativeness of a lot of these data. However, in general the sampling criteria for most studies was strong (e.g. involved all or most young people or practitioners within a service), return rates were acceptable and some studies involved very large numbers of participants (for example, one involved over 1,000 young people). Evaluations of remote interventions included just two Randomised Controlled Trials and four pre/post studies, which are discussed in more detail below.

Overview and characteristics of the different types of remote mental health interventions described in the literature

Key findings: Most studies involved community based mental health services, delivering youth counselling services via online chat or videocall. There was some evidence that young people accessing remote services were experiencing very high levels of psychological distress and complex life challenges.

Most (n=20) remote interventions were community

based, which included mental health support offered by schools, colleges and universities (n=5). Other forms of support were delivered by statutory mental health services (n=15) or within primary care (n=1).

Table 1 (see page 7) gives an overview of the different forms of support described in this review. Most research looked at support delivered by video call, including 'telepsychiatry' offered by statutory services supporting remote communities (e.g. in Australia or Canada) where young people would have otherwise had to travel many miles to access face-to-face support. Online chat services were also common and providing 'real time' online support to young people via text messaging, often outside of traditional office hours.

Interventions were most often described as offering 'general', 'dynamic' or 'supportive' counselling. Very few adopted a specific model of support, however those that did used approaches often associated with brief or short-term therapy, such as Cognitive Behavioural Therapy (Jones et al. 2015; Dowling and Rickwood 2014; 2016; Turner et al. 2009), Motivational Interviewing, Solution Focussed Therapy (Kramer et al. 2014) and Problem Solving Therapy (Dowling and Rickwood 2014; 2016; King et al. 2015). Other interventions focussed on self-management (Nolan, Quinn, and MacCobb 2011), or crisis support (Cartwright et al. 2005), and some included support for families and parents alongside young people, for example a UK-based CAMHS service offered support to families via email, meaning that parents could contact them with updates, request information or raise issues for discussion between appointments (Cartwright et al. 2005).

Some services took a holistic approach, offering remote support for vocational and educational issues alongside counselling for mental health challenges. For example, an online chat service in Australia offered two pathways for young people; esupport and etherapy. E-support included screening and assessment, and supportive counselling, psychoeducation, self-help strategies, and information about other sources of support. Young people who needed a more structured, goal-oriented service were offered etherapy, which involved working on mutually agreed goals using structured, evidence-based therapies, such as Problem-solving Therapy, Motivational Interviewing, and Cognitive Behavioural Therapy (Dowling and Rickwood 2014).

Interventions covered a wide range age groups; most

Table 1: The different forms of remote support included in this review

Type of remote support	Description	Number of studies
Video call	Individual and family support provided via secure video conferencing. Often accessed at home, however in some cases the service was set up so that young people could go to a school or primary health clinic to take the call. Within statutory services this was often called ‘telepsychiatry’, which included anything from a one-off assessment with a psychiatrist, to longer term therapeutic support (e.g 20 sessions) from a mental health professional.	15
Online chat	Individual real time online support via text, often offered by a wide range of mental health professionals (including counsellors, psychologists, nurses, occupational therapists, social workers). Included mental health support (e.g. problem-solving therapy, CBT), information and advice services (e.g. about employment), assessment and signposting. Often time limited, short term and some interventions were anonymous and accessible late into the night and at weekends.	11
Telephone helpline	Anonymous, often single session support from a trained counsellor.	5
Telephone counselling	Therapy (e.g. CBT, psychodynamic) delivered by trained counsellors by phone. Some services could also be accessed by parents and teachers.	4
E-mail	Email support from clinicians and counsellors, including crisis support, support and communication between face-to-face appointments. Some services provided email support to parents alongside young people.	3
Text message	Text messaging between therapists and young people, used to provide support and build the therapeutic relationship between face-to-face appointments.	1
Mixed	Young people had a choice of accessing support via online chat or telephone counselling	2

served under 18s, some were for university age students and others were targeted at young people and adults aged 16-25. Most were open to young people experiencing a wide range of mental health challenges, whilst a minority were for young people with specific diagnoses, such as Obsessive Compulsive Disorder (Turner et al. 2009), Eating Disorders (Yager 2003), suicidal experiences (King et al. 2003; King et al. 2015) or First Episode Psychosis (Lal et al. 2020).

Studies found that young people accessing remote services were experiencing very high levels of psychological distress and complex life challenges. For example, a study of over 1,000 Australian young people accessing online counselling found that, on average, young people had very high scores for psychological distress (indicating severe distress), and low scores for life satisfaction and hope (Dowling and Rickwood 2016). Another study compared young people accessing CAMHS support via video-call with those attending an outpatient service and found similar patterns of psychiatric diagnosis and clinical characteristics between the two groups, however did not run a statistical analysis of these data (Myers, Sulzbacher, and Melzer 2004)

Outcomes of remote mental health interventions for young people

Key findings: Only a very small number of studies conducted a rigorous evaluation of remote interventions, however initial findings suggest that these forms of support can lead to positive outcomes amongst young people, including reductions in the severity of clinical symptoms, increased wellbeing, lower levels of suicidality and stigma

All studies evaluating the effectiveness of remote mental health interventions for young people reported positive outcomes, including reductions in the severity of clinical symptoms, increased wellbeing, and lower levels of suicidality and stigma.

Randomised Controlled Trials (RCTs) are widely considered to be the most reliable way to evaluate an intervention; two RCTs met the criteria for inclusion in our review and both evaluated web chat interventions. One was an evaluation of ‘eBridge’, a chat intervention which used motivational interviewing and a behavioural approach to support students experiencing suicidal thoughts and feel-

ings. The study found that students accessing eBridge were more likely seek support from family, friends and mental health services and also reported lower levels of stigma after accessing the intervention, compared with young people who received no support (King et al. 2015). Another RCT found that young people who accessed 'PratenOnline chat', a Solution-Focused Therapy chat intervention, reported a significant reduction in symptoms of depression, compared with those who were waiting for support (Kramer et al. 2014). When comparing this with findings reported in evaluations of traditional mental health services, the authors reported that 'PratenOnline chat' had outcomes that matched and even exceeded those of face-to-face support for young people.

Further evidence for the effectiveness of remote support was provided by studies which looked at change in outcomes after young people had accessed an intervention (pre/post studies). These types of studies are limited as it is not possible to know whether any change in outcome is due to the intervention, or other factors (e.g. young people feel get better over time without accessing support), and so are less reliable than RCTs. Two evaluations of chat counselling reported significant reductions in psychological distress (Dowling and Rickwood 2014) and improvements in wellbeing (Street, 2013), whilst studies of telephone support reported decreased suicidality (King et al. 2003), and a reduction in symptoms of OCD (Turner et al. 2009).

One evaluation of a helpline and online chat service found that young people reported a higher sense of wellbeing and a reduction in the severity of their problems one month after accessing support, and that young people who had used the chat (vs the telephone) service reported the greatest improvement (Fukkink and Hermanns 2009). A number of case studies also reported positive outcomes for support delivered by video call, such as a reduction in symptoms, and discontinuation of medication (Alessi 2003; Bischoff et al. 2004).

No studies reported any evidence that remote interventions caused harm to young people accessing them.

Acceptability amongst young people and families

Key findings: Survey studies found that most young people were interested in trying remote mental health support, however the majority of those attending face-to-face sessions were not comfortable with this being used as a replacement for in-person services. Most young people who were accessing online chat or telephone support reported high levels of satisfaction and said their preference was to receive support in this way rather than a face-to-face inter-

Survey studies exploring the acceptability of remote interventions amongst young people reported that most young people were interested in trying remote mental health support. A survey of Australian students found 80% said they definitely or might use online counselling if it were available (Glasheen, Shochet, and Campbell 2016). Another study in Canada reported that 82% of young people currently accessing mental health services were open to receiving support from their care team via videocall, but that 63% felt it shouldn't be used to replace face-to-face sessions with clinicians- meaning that the majority of young people would not be comfortable with receiving remote as a substitute for in-person support (Lal et al. 2020). A study of young people using a text based counselling service in Australia found that 63% said it was not any more helpful than other services they had previously accessed, and just 31% felt it would be an effective way of supporting young people with complex, long term mental health challenges (Navarro et al. 2019).

Studies exploring the experiences of young people who had used remote support, however, found that whilst they often initially felt anxious, or reluctant about support being delivered in this way, after accessing the service they were comfortable using it and reported high levels of satisfaction (Savin et al. 2006; Bischoff et al. 2004; Nelson and Bui 2010; Myers, Valentine, and Melzer 2007; Cathy Street 2017).

The majority of young people who were accessing online chat or telephone support said their preference was to receive support in this way rather than a face-to-face intervention (Street, 2013; Fukkink and Hermanns 2009). Interestingly, a survey of 14-19 year old students found that over half said telephone helplines were their preferred form of support, followed by face-to-face sessions (Youthline 2008)

Young people's engagement in remote support

Key findings: Studies where young people did not have a choice about whether or not they accessed remote support (e.g. when they were randomly selected to receive remote support), reported very high dropout rates, however when young people had chosen to access this type of support, drop out rates were much lower.

There were mixed findings regarding attrition (drop out) rates for remote support. One study evaluating a telephone counselling service reported very low attrition rates (Lingley-Pottie and McGrath 2008), whilst studies of web chat interventions found that many young people did not engage, or would only access support for one or two sessions (Dowling and Rickwood 2014; 2016). For example an Australian study of a school-based intervention for

students experiencing suicidal thoughts found just 29% of young people posted more than one message (King et al. 2015), and another found that 58% of young people with a diagnosis of depression who signed up to access online support did not have any conversations with their therapist at all (Kramer et al. 2014).

Acceptability amongst practitioners

Key findings: Many studies reported high levels of resistance to this way of working amongst practitioners, even when young people had expressed a preference for this type of support, or when services had trialled these forms of support with positive outcomes. However, some of these findings may be out of date as many more practitioners now have experience of working remotely. Factors influencing acceptability of remote support amongst practitioners included age, experience of using technology in their daily life, attitudes towards technology (e.g. the internet), and their professional values and beliefs about their role and responsibilities. Most studies conducted in services which were delivering forms of remote support reported high levels of satisfaction amongst clinicians, however, one found that clinicians limited the use of this service, despite it being popular amongst young people.

Studies of the views of practitioners found that before the Covid-19 pandemic remote ways of working were generally not widely used nor considered to be part of standard practice, and where they were adopted these approaches were often seen as an adjunct to face-to-face support. It is likely that some of these findings may be out of date now, as many more practitioners have experience of working remotely.

Many studies reported high levels of resistance to this way of working amongst practitioners, even when young people themselves had expressed a preference for this type of support, and when services had trialled them with positive outcomes (Cartwright et al. 2005; Grealish et al. 2005). For example, a UK study exploring the potential use of email with families accessing CAMHS found that just 25% of clinicians felt comfortable with offering support in this way (Cartwright et al. 2005). Another exploring the use of video calls within a UK CAMHS found that managers were unwilling to allocate funding to support the implementation of remote ways of working, even where costs were small and represented improvements in the process of care for young people, because of resistance towards these practices amongst staff (Grealish et al. 2005).

Qualitative (i.e. interview or focus group) studies, found a range of factors influenced practitioner's decisions

about if and how they planned to support young people remotely, including individual factors such as their age, experience, and beliefs about technology. Practitioners who often used technology (e.g. internet forums or chat) in their daily life were found to be more willing to use it to support young people, whilst those that held negative beliefs about these methods of communication (e.g. that internet use resulted in cyberbullying, or obsessive use of social media,) were more resistant to this way of working. Some participants were also influenced by previous negative experiences with technology at work, such as a lack of streamlining between databases (Orlowski et al. 2016; Cathy Street 2017).

Practitioners often viewed web chat, telephone or email support as being at odds with their professional identity and skillset. Many felt they would be unable to provide meaningful and effective support to young people, and develop a strong therapeutic relationship, without a level of personal, human connection which they believed could only be achieved through face-to-face engagement. Others were concerned that working remotely would impact their ability to assess risks, or a young person's mental state, and could lead to them neglecting their legal responsibilities and professional duty of care (Orlowski et al. 2016).

Most studies conducted in services which were delivering forms of remote support reported high levels of satisfaction amongst clinicians, although many were initially hesitant about delivering support in this way (Myers, Valentine, and Melzer 2007; Barak and Wander-Schwartz 2000; Wood et al. 2012). A survey of clinicians working in an Australian CAMHS delivering support via videocall found that 94% agreed that all or most needs were met by the service (Wood et al. 2012). Clinicians in interview and case studies of online web chat and video call interventions said they felt that this was a valuable and effective way of delivering support (Myers, Valentine, and Melzer 2007; Barak and Wander-Schwartz 2000; Nelson and Bui 2010). However, one study of videocall support implemented in a UK CAMHS found that clinicians limited the use of this service, despite it being popular amongst young people (Grealish et al. 2005).

Organisational barriers to implementation

Key findings: Many studies found that practitioners often felt under resourced under prepared to adopt remote methods of support, including concerns about a lack of skills and training and clear policies and procedures, limited access to equipment and resources and a lack of time. This may have changed during the pandemic as a number of resources (e.g. around safeguarding) have now been developed to support practitioners working in this way.

Research conducted before the Covid-19 pandemic suggests that a range of organisational factors meant practitioners often felt under resourced, and under prepared to adopt remote methods of support, and so were resistant to using these approaches in their practice (Orlowski et al. 2016; Cartwright et al. 2005; Cathy Street 2017). These included concerns about a lack of;

1. **Skills and training**, particularly around assessment of needs and mental health, safeguarding, confidentiality, management of risk, how to support young people with diagnoses such as schizophrenia or borderline personality disorder (e.g. concerns about maintaining boundaries and a subsequent increase in contact), and knowledge and practical skills around using technology.
2. **Policies and procedures** outlining how this type of support should be delivered in a safe, ethical and effective way, and how to ensure that the support offered during face-to-face and online counselling was aligned.
3. **Access to equipment and resources** required to deliver remote support, such as computers, or a stable internet connection, and concerns about a lack of funds to supply the resources required.
4. **Time**; with many practitioners viewing integration of these practices as being 'extra work', on top of an already full workload. Some clinicians were concerned that being contactable by email or internet chat would mean responding to young people outside of their working hours, that they might be expected to respond immediately, thus reducing their capacity for other clinical work. Some were also worried that being open to these forms of communication the number of contacts they had with young people would increase in an unmanageable way.

Alongside these reservations, however, some practitioners believed using these methods of communication enabled them to meet young people 'where they are', which promoted opportunities for connection and belonging (Orlowski et al. 2016). Practitioners also recognised some benefits of remote support, including viewing it as a way to reach out to young people who might not usually access their service or who may be anxious about attending counselling in-person, to reduce waiting times, to support young people waiting to access statutory services, and to develop their own counselling skills and understanding of online provision (Cathy Street 2017).

Accessibility

Key findings: A number of studies concluded that remote interventions were an effective way of supporting young people who find it difficult to access

face-to-face counselling. Some young people and practitioners felt remote services were more flexible and accessible compared with face-to-face counselling, because:

- Support was available outside of office hours
- Young people generally had a shorter wait to access remote support and less time to wait between sessions
- Young people had to take less time out from work or school to attend appointments
- Young people did not have to rely on parents or carers for transport
- Support could be accessed whilst young people were at home, in a comfortable and familiar environment

However studies of 'drop-in' online chat services found that young people would often have to wait in an online queuing system for several hours before speaking with a counsellor and there was no guarantee they would be able to access support before the service's closing time. There were also limits around how responsive remote services could be in 'real time', especially when communication was by email or text. Issues with technology could disrupt access (e.g. problems with the sound or video quality of a call). There were also concerns that remote support would not be accessible to young people who did not have access to a computer or phone, or the internet.

Despite the high drop-out rate reported by some studies, there was a general sense that remote interventions were an effective way of supporting young people who find it difficult to access face-to-face counselling, including young men, young carers, young people with disabilities or those living in remote locations and young people experiencing life problems which might be associated with strong feelings of stigma or shame such as challenges linked to their gender identity or sexuality (Street, 2013; Orlowski et al. 2016).

Young people and practitioners felt remote services were more flexible and accessible compared with face-to-face counselling as support was available outside of typical office hours, including at weekends and late into the evening. Young people also had a shorter wait to access these services, had less time to wait between sessions, had to take less time out from work or school (i.e. to travel to and from appointments) and did not need to rely on parents for transport (Street, 2013; Orlowski et al. 2016). Some studies consequently positioned remote

support as opening up opportunities for early intervention (Nelson and Bui 2010).

However some studies of 'drop-in' online chat services found that young people would often have to wait in an online queuing system for several hours before speaking with a counsellor. Young people accessing a telephone and online chat service found there was no guarantee they would be able to access support on any given day before the service's 9pm closing time, which compounded feelings of depression (King et al. 2006). In these cases young people suggested that an online chat room would be helpful whilst they were waiting. There were also limits around how responsive remote services could be in 'real time', especially when communication was by email or text. There were concerns that young people could be left feeling isolated, or 'neglected' if practitioners were not able to give a timely reply (Yager 2003). Others studies, however, noted that this type of communication gave the practitioner more time to reflect on and craft a response, or seek support from their colleagues if they needed it (Mehta and Chalhoub 2006; Dowling and Rickwood 2014).

Remote support could be accessed whilst young people were at home, in a comfortable and familiar environment, and so could be less stressful than attending a service in person, for example, during a time when a young person was experiencing high levels of anxiety (Turner et al. 2009; Street, 2013; Nelson and Bui 2010). However, studies also noted that home was not always a safe place for young people, because of family conflict or abuse, and some young people felt concerned that they would be overheard by family members when accessing support at home (King et al. 2006). Very few studies reported issues with the technology underpinning remote support, however when this did occur it could disrupt access; some studies gave accounts of problems with the sound or video quality of a call, or where poor signal caused counselling sessions to end prematurely (Savin et al. 2006). There were also concerns that remote support would not be accessible to young people who did not have access to a computer or phone, or the internet (Mehta and Chalhoub, 2006)

Emotional safety and stigma

Key findings: Young people accessing remote support said these services felt safer than in-person sessions, which meant they felt more able and willing to discuss their experiences within these contexts. They chose to engage with remote support to minimize the risk of them being judged, or experiencing other challenging reactions such as misgendering, or feelings of stigma. Some young people found the prospect of 1:1 support 'scary', overwhelming and

uncomfortable and so wanted to minimize social or verbal interaction with a therapist.

In survey and focus group studies young people said they felt less vulnerable when accessing remote forms of support, which were described as being safer and less stressful, stigmatising and intimidating than attending sessions in-person (Street, 2013; Fukkink and Hermanns 2009; Glasheen, Shochet, and Campbell 2016). For example, 94% of young people accessing an Australian online counselling service said it felt safer than face-to-face counselling, and 72% did so to reduce the 'emotional intensity' of the conversation (Navarro et al. 2019).

Young people often said they chose to engage with remote over in-person support to minimize the risk of them being judged, or experiencing other challenging reactions such as misgendering, or feelings of stigma because they were accessing a mental health intervention (Fukkink and Hermanns 2009; Glasheen, Shochet, and Campbell 2016; Navarro et al. 2019). A survey of Australian school students found that young people who intended to seek help online were more likely to want to discuss sensitive issues such as sexuality, compared to those who expressed a preference for face-to-face support (Glasheen, Shochet, and Campbell 2016). In a focus group studies young people said they accessed online counselling because, *"the counsellor can't tell if I'm crying"*, *"I feel less ashamed"*, *"I find calling difficult, because I'm afraid I'm to cry"* and *"(if I talk to them in person) the counsellor will think I'm weird"* (Fukkink and Hermanns 2009; King et al. 2006). Some young people also said they chose to access support remotely because they were worried about being seen attending appointments within their community (Lingley-Pottie and McGrath 2008; Navarro et al. 2019).

Some young people said they found the prospect of 1:1 support 'scary', and uncomfortable, and so wanted to minimize social or verbal interaction with a therapist. They felt this reduced the risk of them becoming overwhelmed when talking about distressing experiences during a session or feeling like they needed to modify or inhibit their response during therapy. One case study reported that a benefit of asynchronous (i.e. not in 'real time') remote support, such as emails, was that young people did not worry or feel guilty about imposing on clinician's time as they knew clinicians could check their messages when it was convenient for them (Yager 2003). However, for others young people experiencing a level of personal connection was important (Navarro et al. 2019; Yager 2003). For example, study of a Dutch service offering both telephone and web chat support found that young people using the helpline wanted to receive what felt like a 'real' and human response to their experiences (*"letters don't show emotions"*), whilst those accessing the chat services found that the anonymous ('faceless'

and ‘voiceless’) nature of the support (“*voice is overpowering*”) provided a secure environment in which they felt safe to share their story (Fukkink and Hermanns 2009).

Confidentiality and privacy

Key findings: Practitioners and young people felt there were inherent risks to privacy associated with text based interventions such as email or web chat, which raised ethical and legal concerns for staff around consent, confidentiality, and if and how to store records of conversations. Despite this, a number of studies found young people expressed a preference for text-based support over phone counselling because they felt it was more private.

Both practitioners and young people felt there were inherent risks to privacy associated with text based interventions such as email or web chat, which raised ethical and legal concerns for staff around consent, confidentiality, and if and how to store records of conversations (Yager 2003; Mehta and Chalhoub 2006). For example a survey of staff within a CAMH service considering the use of email support found 40% of staff rated their understanding of these issues as being limited (Cartwright et al. 2005). Practitioners felt that clear policy and guidance was required around how to safely manage these issues, and many working within these services felt it was their responsibility to ensure young people had considered their needs for privacy, which was difficult to achieve (Street, 2013). A main concern was that messages could be intercepted and read by others, including roommates or family members, accessed by hackers, or the records destroyed by a virus (Fukkink and Hermanns 2009; Yager 2003; Mehta and Chalhoub 2006).

Despite these concerns, a number of studies found young people expressed a preference for text-based interventions over phone counselling because of worries about being overheard by family members (Fukkink and Hermanns 2009; King et al. 2006; Navarro et al. 2019). Young people accessing this type of support often described having to wait until the house was empty before taking a call because of these issues (King et al. 2006), and so viewed text as a more private way of communicating because it was easier to conceal from those around them (Navarro et al. 2019; Fukkink and Hermanns 2009).

The therapeutic relationship

Key findings: Studies with practitioners working within remote services found it was possible to develop strong therapeutic relationships within these contexts, however noted that this was more difficult, and often took more time than when meeting with the young person face-to-face. Some studies noted

that young people and practitioners within remote services were in contact more often compared with in-person support, and young people reported this could create a sense of a continuous supportive presence in their life. Most remote support was time limited and described as ‘brief’, and there was a sense that although valuable, remote interventions were often not long enough, both in terms of the number and length of individual sessions. One study found that therapists were often unable to progress to the later (more impactful) goal planning stages of the therapeutic process as young people disengaged after just a few sessions. This was particularly an issue for text-based interventions, where practitioners noted the pace of communication was much slower than talking in person.

In number of studies practitioners expressed concerns about establishing a strong therapeutic relationship when supporting young people remotely (for example, because they believed technology limits opportunities for connection and engagement), and that this would have an adverse impact on outcomes (Orlowski et al. 2016; Savin et al. 2006; Cartwright et al. 2005). Some felt remote support would be most beneficial when used as a way of building or repairing the therapeutic relationship between face-to-face appointments (e.g through text or email contact) rather than as a standalone intervention (Nolan, Quinn, and MacCobb 2011; Orlowski et al. 2016; Mehta and Chalhoub 2006).

Studies with practitioners working within remote services found it was possible to develop strong therapeutic relationships within these contexts, however noted that this was more difficult, and often took more time than when meeting with the young person face-to-face (Dowling and Rickwood 2014; Savin et al. 2006). In one study young people reported experiencing a strong therapeutic alliance with practitioners who supported them remotely (Lingley-Pottie and McGrath 2008), and another study of a Canadian service offering telephone CBT used a questionnaire to measure the quality of the therapeutic relationship, and found that a positive relationship can occur when counselling is accessed remotely (Lingley-Pottie and McGrath 2008).

Some studies noted that young people and practitioners within remote services were in contact more often compared with in-person support, and young people reported this could create a sense of feeling held (e.g. a continuous supportive presence), and particularly valued having the option to reach out to the therapist (e.g. by email) when they needed to (Yager 2003; Cartwright et al. 2005; Christogiorgos et al. 2010).

A case study of a telephone support service concluded

that the impersonal nature of these relationships could mean there was more tolerance of mistakes, and more space for the therapist to be perceived as ‘good’ or ‘ideal’, in the eyes of the young person (Christogiorgos et al. 2010). Young people accessing a web chat intervention described web counsellors as being “*always nice*” and that “*you never feel like you are bothering them (as opposed to phone)*”. This study reported that a loss of some emotional range in communication could have unexpected positive impact on the therapeutic relationship for some young people, however it is also likely that these young people chose to access remote support because they wanted to limit social contact with their therapist (King et al. 2006).

Most remote support was time limited and described as ‘brief’, and there was a sense that although valuable, remote interventions were often not long enough, both in terms of the number and length of individual sessions (King et al. 2006; Barak and Wander-Schwartz 2000; Dowling and Rickwood 2014). For example, therapists delivering seven sessions of online group therapy to university students felt that the intervention was too short to support significant and long-lasting change (Barak and Wander-Schwartz 2000). This was particularly an issue for text-based interventions, where practitioners noted the pace of communication was much slower than talking in person (Dowling and Rickwood 2014). Fukkink et al., (2009), analysed the content of conversations in a helpline and chat service and found that 143 words per minute were communicated on the helpline, vs just 31 words per minute in the chat service. Consequently some counsellors felt online support wasn’t well suited to structured forms of therapy requiring multiple sessions, such as Cognitive Behavioural Therapy, and instead chose to use a more open ‘person centred’ approach (Dowling, 2013). One study conducted a content analysis of chat counselling sessions and found that the more sessions a young person attended the greater the improvement in levels of psychological distress, however that therapists were often unable to progress to the later (more impactful) goal planning stages of the therapeutic process as young people disengaged after just a few sessions (Dowling and Rickwood 2014). This was also identified as being a challenge within a telephone counselling services because young people did not need to commit to a specific number of sessions, which made it difficult for therapists to plan their approach and find ways of offering support that had the required amount of depth, and goal setting to meet the young person’s needs (Christogiorgos et al. 2010)

Power and control

Key findings: Remote interventions were seen to challenge traditional dynamics within the therapeutic relationship by shifting power from the practitioner to the young person, and many young people said they chose to access remote support because it gave them a more control over their personal information and the therapeutic process. Accounts from practitioners revealed feelings of vulnerability and discomfort about being out of control, e.g. when they could not ‘see’ what a young person was doing, or access information about them.

Themes of power and control were prevalent in the literature and central to the experiences of both young people and practitioners. Remote interventions were seen to challenge traditional dynamics within the therapeutic relationship (where the clinician is positioned as the ‘expert’), by shifting power from the practitioner to the young person. It was noted that young people in particular have a need for self-determination and privacy (Christogiorgos et al. 2010), and many said they chose to access remote support because it gave them a more autonomy over the therapeutic process. For example, a survey study found 56% of young people accessing an online chat service said they did so because it gave them a greater sense of control (Navarro et al. 2019). Accounts from practitioners revealed feelings of vulnerability and discomfort when they felt out of control, e.g. when they could not ‘see’ what a young person was doing, or access information about them (Orlowski et al. 2016; Street, 2013).

The anonymity and privacy provided by many remote interventions meant young people were in control of their personal information e.g. what information they wanted to share, how and when this was shared, and who had access to it (Dowling and Rickwood 2014). Remote support enabled them to discuss situations involving a level of risk without concerns that the counsellor would need to report this to the authorities, and meant they could access support without their parent being informed (Navarro, 2019). Young people accessing web chat or email interventions said being able to take their time constructing their responses, and edit and delete what they had written gave them a sense of control and comfort (Fukkink and Hermanns 2009; King et al. 2006; Yager 2003). Correspondingly, practitioners gave accounts of how they were unable to collect the information they wanted due to the level of autonomy and control granted to the young person (Dowling and Rickwood 2014).

In a number of studies young people described that they felt more comfortable and able to leave a session when they wanted to when accessing remote vs face-to-face support (Dowling and Rickwood 2014; Grealish et al. 2005; Christogiorgos et al. 2010). In a case study of a telephone counselling service practitioners described how this meant the young person was in a position of power,

and presented a challenge to therapists who may be left with strong feelings (described in this paper as ‘counter-transference reactions’) of helplessness, hostility, guilt or inadequacy (Christogiorgos et al. 2010).

Some practitioners reflected on their relative lack of knowledge and understanding of the technology used to deliver remote support (such as internet forums), and lack of confidence in using this type in their practice, compared to young people, who were seen as confident users of technology with a high level of skill in this area. It was noted that this opened up opportunities for young people to be seen as the ‘experts’ and so occupy a position of power within the therapeutic relationship. Some practitioners felt that their resistance to using these approaches may partly be because of vulnerabilities linked to their lack of skills in this area (Orlowski et al. 2016).

Safety and safeguarding

Key findings: Risk management was identified as a major concern in many studies. Counsellors reported that they often supported young people who disclosed self-harming behaviours, suicidal thoughts, and sexual abuse. These practitioners had to find ways of coping with feelings of helplessness and fear when they were not able to take action to protect a young person as they would if they were supporting them face-to-face. Practitioners also described having a limited understanding of the legal and ethical issues around confidentiality and data management in relation to remote support. Studies concluded that those managing and supporting teams who are offering remote interventions should have an understanding of the unique challenges that can be experienced when communicating with young people in this way, and that spaces should be provided where therapists can discuss these issues

Unsurprisingly risk management was identified as a major concern in many studies. Introducing technology, such as web chat, as a way of supporting young people was seen to increase risk, e.g. to confidentiality, because of concerns about how data would be stored (Orlowski et al. 2016). Practitioners also described having a limited understanding of the legal and ethical issues around confidentiality and data management; for example, a survey within a CAMH service considering the use of email support found 40% of staff rated their understanding of these issues as being limited (Cartwright et al. 2005). Whilst some staff called for clear and detailed policies and procedures around these issues, others were concerned that this could result in ‘prescriptive work practices’ and hinder innovation, giving examples of how current policies prevented them from downloading apps and

other potentially useful programs onto work computers (Orlowski et al. 2016).

Within these discussions practitioners underlined their ethical and legal responsibility to accurately assess risks to young people, and frequently expressed concerns that they would not be able to do this when supporting young people remotely because of the communication challenges (described below) associated with remote support (Orlowski et al. 2016; Yager 2003). There were particular concerns that asynchronous support (i.e. that was not delivered in ‘real time’) prevented practitioners from being able to respond as required to urgent, high risk, situations, and act to protect young people (Orlowski et al. 2016; Yager 2003).

Counsellors working in online chat and email services described how they often supported young people who disclosed self-harming behaviours, suicidal thoughts, and sexual abuse, and the challenges that came with managing risks when offering support online, when they didn’t have access to information such as family or emergency contact details (Dowling and Rickwood 2014; Cartwright et al. 2005; Street, 2013). These practitioners had to find ways of coping with feelings of helplessness and fear when they were not able to take action to protect a young person as they would if they were supporting them face-to-face; *“Often we’re working with very little information; we may not actually know their address or their telephone number. So we have to sit with risk and so it’s quite profound at times and just let go whereas otherwise you’d have them in the room or you’d know where they lived and you would act accordingly”* (Dowling and Rickwood 2014).

A number of studies addressed the support needs of practitioners within these services and concluded that those managing and supporting teams offering remote interventions should have an understanding of the unique challenges that can be experienced when communicating with young people in this way, and that spaces should be provided where therapists can discuss these issues, e.g. during supervision (Street, 2013). For example, this work required practitioners to learn to sit with feelings of fear, helplessness and guilt when a young person might disclose an incident of abuse, or staff may hear conflict at home play out in the background during a phone call (Christogiorgos et al. 2010). Practitioners working remotely also may experience feelings of isolation because they themselves may be working remotely, in a small team, or outside of normal working hours (Street, 2013). A telephone counselling service made space for check-ins between therapists during and at the end of the shift, where they could *“confront and process their own unresolved conflicts, and recognise and handle the countertransference phenomena that develop during the course of the sessions”*. In this service counsellors

were required to take a break between calls to help them unwind and they had weekly supervision sessions with a mental health specialist, as well as group sessions with an external supervisor every fortnight (Christogiorgos et al. 2010).

Challenges and adaptations when communicating remotely

Key findings: A common theme across many studies was the unique challenges encountered when communicating remotely, including:

- Delays or disruption to communication due to poor signal
- Poor signal causing the session to end prematurely
- Disruption due to background noise
- Loss of non-verbal communication and eye contact
- Loss of control because the young person could end the session at any time, without warning.
- Difficulties recognising and using therapeutic tools and processes such as transference, countertransference and silence
- Increased possibility of miscommunication, or misinterpretation when communicating via text
- Concerns that young people would not be giving the session their full attention (e.g. because they could be visiting websites, etc whilst online)
- Difficulties judging a young person's literacy level when communicating via text
- Managing boundaries when offering support via webchat so communication did not begin to feel inappropriate or overly familiar

Practitioners made the following adaptations to facilitate the therapeutic process within these contexts:

- Slowing down the pace of communication and pausing before responding
- Deliberately exaggerating non-verbal behaviours
- Asking young people about their non-verbal behaviour to ensure they were interpreting it correctly
- Introducing the most significant issues early on in the session, or planning shorter video sessions followed up with a phone call

- Focussing on the tone and intensity of the young person's voice
- Mirroring the language used by young people
- Using simple language when communicating via text
- Using an informal and open style of text communication, including emoticons, acronyms, slang, nicknames (e.g. "kiddo"), capital letters, and virtual hugs
- Setting a time limit for webchat sessions

A few studies concluded that those working in remote services 'face the same successes and challenges as face-to-face sessions', including completing relevant paperwork, building rapport, tailoring strategies to meet the individual needs of the young person, and encouraging sustained practice of therapy strategies at home (Nelson and Bui 2010). However, a common theme across many studies was the unique challenges encountered when communicating remotely, and the adaptations practitioners made to facilitate the therapeutic process within these contexts. These are discussed below.

Videocall

A number of case studies provided detailed accounts of the challenges encountered by practitioners when providing support via videocall (Nelson and Bui 2010; Alessi 2003; Savin et al. 2006; Bischoff et al. 2004), the main challenge being delays because of poor internet signal, which interrupted the flow of communication, and in some cases caused the session to end prematurely, or meant it did not happen. One study noted the therapist found the signal delay most disruptive at the beginning of a session, where he was trying to 'join' or make a connection with the client (e.g. through small talk), because of the different pace of communication at this stage, compared to the 'working stages' of therapy (for example, timing could be an issue when either he or the young person wanted to make a joke). Others found that even a very short delay interfered with normal patterns of communication, such as at times when the therapist would interject to show agreement, or support (e.g. by saying "yes" or "u-hum"). Therapists and young people described how they were able to adjust and compensate for any signal delay by slowing down the pace of communication and pausing before responding;

Client A, explained, "*I've just gotten to the point where I wait a couple seconds before I respond. It's not all that difficult to get used to. It's not all that bad . . . it just took a little bit longer to say something and get a [response] back. After I got used to it, it was all right.*" (Bischoff et al. 2004)

On balance, studies suggested that a main challenge

was the loss of non-verbal communication, such as body language. In one case study a family member described the sessions, as being like *“talking to the TV”* and explained *“If you had somebody who was really wanting to hide what they were feeling and what they were doing, I think it would be very easily done this way”* (Bischoff et al. 2004). Researchers in this study analysed recordings of counselling sessions and found that to compensate therapists often deliberately exaggerated non-verbal behaviours, and that as the sessions progressed this way of communicating was also adopted by young people. During these calls therapists also often directly asked young people about their non-verbal behaviour, to ensure they were interpreting it correctly. In cases where the internet connection was very poor and there was a risk of the connection terminating, therapists learned to introduce the most significant issues early on in the session, or planned shorter video session followed up with a phone call. There was a sense amongst therapists and young people within this service that these adaptations meant the therapy worked in a similar way to face-to-face support and helped to preserve the therapeutic relationship (Bischoff et al. 2004)

Telephone

Just one study gave an account of the challenges encountered when offering support by phone (Christogiorgos et al. 2010). In the absence of eye contact therapists found it helpful to focus on the tone and intensity of the young person’s voice. Background noise could also disrupt the session, and practitioners struggled with the knowledge that the young person could end the session at any time, without warning, and were challenged by this loss of control. Therapists noted it was more difficult for them to recognise and use processes such as transference, countertransference and silence when supporting young people over the phone (Christogiorgos et al. 2010). These were important components of communication, often used to help the therapist understand the young person’s emotional needs and experiences of conflicts and resistance within the therapeutic relationship. Silence can be used by the therapist to communicate safety, understanding and containment, however practitioners offering support over the phone found that silence was often difficult to understand and could be easily interpreted as distance or disengagement, or that the caller was no longer on the line.

Text

A main concern of both young people and practitioners within chat, or text-based support services, was the increased possibility of miscommunication, or misinterpretation (Dowling and Rickwood 2014; Orlowski et al. 2016). Practitioners described how this form of communication could often feel “sporadic” or “disjointed”, and were concerned that young people would not necessarily

be giving the session their full attention, e.g. because they were visiting other websites, or watching television etc whilst online (Dowling and Rickwood 2014). They were also concerned that vulnerable young people may misunderstand what they were communicating, causing them further distress (Yager 2003).

One focus group study found that most young people accessing a web chat service had experienced some level of misunderstanding between them and the counsellor (King et al. 2006). Some young people found it difficult to type when they were feeling upset, whilst others were worried the counsellor might not be able adequately to grasp their feelings or emotions through text, and also found it difficult to get a sense of what the therapist was thinking or feeling (King et al. 2006). Some young people, however, felt it was easier to type how they were feeling than speak about it in person, both because of the anonymity provided by this form of communication, and also because it they had more space and time to organise and articulate their thoughts and ideas, and to follow the conversation (Navarro et al. 2019; King et al. 2006; Fukkink and Hermanns 2009).

Some studies reported that young people could interact less formally online, and a study comparing face-to-face vs online group therapy found both positive and negative processes underlying interpersonal relationships, such as support and aggression, unfolded much quicker online (Barak and Wander-Schwartz 2000). Some practitioners were concerned that the anonymity afforded by remote support, especially web chat, meant young people could become disinhibited or abusive (Street, 2013; Yager 2003). There was, however little evidence of this in the literature; just two evaluations of web chat and email support noted a few cases where staff received hostile or threatening messages from young people, for example swearing at clinicians (Cartwright et al. 2005; Dowling and Rickwood 2014).

In one focus group study practitioners described how they tried to use basic language when supporting young people via text or chat as it was difficult to judge a young person’s literacy level, and that, in their experience, using more complex language could cause the young person to disengage (Dowling and Rickwood 2014). They also used a more informal and open style of communication, including emoticons, acronyms, slang, nicknames (e.g. “kiddo”), capital letters, and virtual hugs to show support and mirror the young person’s chat, e.g. one practitioner explained *“I think just that mirroring of you know, ‘I’m having such a bad day’ — sad face. And it’s like ‘I’m sorry you feel that way’ – sad face.”* However there was also a sense that practitioners needed to strike a balance when communicating in this way, to ensure that communication did not begin to feel inappropriate or overly familiar. When communicating via text boundaries were

especially important, and some services set a time limit for webchat sessions as a way of managing this. Practitioners also felt it was important to do “a lot of checking in to make sure that what you’re trying to communicate has been communicated well”, and that being able to engage a young person and make them feel validated was

a key skill for working online, as one participant noted, “validation of their emotions, and their circumstances, can be quite a significant contribution to their situation even if it doesn’t feel like you’ve given them a kind of therapeutic program” (Dowling and Rickwood 2014).

Discussion

Our aim in conducting this review was to summarise current evidence of the impact and implementation of remote mental health interventions for young people to support evidence-informed decision making in policy and practice across mental health services, both during and in the aftermath of the Covid-19 pandemic.

There were very few robust evaluations of remote support, however those included in our review suggest it can lead to improvements in young people’s mental health and wellbeing. There were examples of how these interventions can enable services to work flexibly and adapt their ways of communication to fit the needs of the young person. For example, by providing a standalone intervention for young people with strong preferences for support that is flexible, anonymous and private, and where they have a high level of autonomy. In other cases text or email could be used between face to face appointments to communicate with family members, or develop or repair the therapeutic relationship with a young person, and young people who may find it difficult to access face-to-face support due to a change in life circumstances or mental health can be offered remote support as an alternative during this time. In this sense, remote interventions, when offered alongside face-to-face support, can help to build a service that is truly young person-centred, giving young people more choice and control over how, and how much, they want to engage, whilst making the service accessible to those who find it difficult to attend face-to-face support.

Our findings suggest that using remote interventions as a replacement for face-to-face support (as was necessary during the Covid-19 pandemic) is problematic. Young people who chose to access remote interventions were generally very happy with these services, however the vast majority of those who were attending face-to-face sessions said that remote support would not be a suitable substitute. There were also very high dropout rates in trials of remote interventions (where young people are randomly selected to receive a remote intervention, rather than choosing to access it themselves), demonstrating

that remote interventions are clearly not suitable for all young people.

Remote interventions were typically described as ‘brief’, meaning sessions were largely focused on providing space for the young person to tell their story, and practitioners often did not have time to identify action plans or goals. This is likely to affect outcomes (as attending more sessions is likely to lead to greater change), however it’s also important to recognise that some young people may chose remote support because they do not feel ready to engage in longer term therapy. It may be useful for practitioners to consider how their approach could be adapted to provide the most impact over a small number of sessions, possibly by offering a structured single session intervention (Hymmen, Stalker, & Cheryl-Anne, 2013), or brief goal-directed interventions where action plans are co-produced, if this is something the young person feels could be helpful (Feldman and Dreher 2012). Some training around how to increase engagement might also be useful, for example, by explaining to young people that longer term engagement is likely to lead to greater change, identifying and focusing on the issues that are most concern to them in the initial session, etc.

Staff often felt that remote support was not aligned with their professional values, role and responsibilities, and findings illustrated that offering support in this way can require staff to re-think their ways of working and identity. This may be less of an issue following the pandemic, as many more staff will now have experience delivering remote support, however, could still be a challenge for newly qualified practitioners, or those who were furloughed. There was also some evidence that staff can remain resistant to providing remote support in services that had adopted it, even when it was working well and was popular amongst young people, illustrating how it can pose a significant challenge to some staff. In these cases, training around the strengths of remote support, and the experiences of young people may be helpful. This should also be included in undergraduate and entry level training for mental health practitioners.

In the aftermath of the Covid-19 pandemic there is a need for more robust evaluations into the effectiveness of remote support, including comparative studies looking at the outcomes of remote vs face-to-face interventions. It is also now necessary for more research into the experiences and perspectives of staff, who are likely to be far more familiar with these types of interventions, to help us understand if and how the challenges presented in this

report may have changed. We also need research to help us understand the experiences of young people, particularly those who had to switch from face-to-face to remote support during lockdown, and those who would not otherwise have chosen to access remote support.

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Appendix

Search strategy

Using the terms below we searched electronic databases (via pubmed) for all reviews published since 1960. This search returned 52 reviews. Relevant reviews were then screened for original research papers, and relevant data were extracted from any that met the inclusion criteria. We also searched original research studies published since January 2018. This search returned 74 papers. Abstracts were screened for relevance.

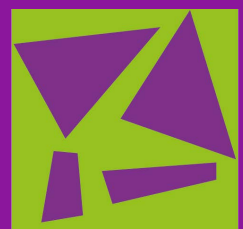
Search terms: (young people*[Title/Abstract] OR adolescent*[Title/Abstract] OR teen*[Title/Abstract] OR child*[Title/Abstract] OR youth[Title/Abstract] OR young[Title/Abstract]) AND (phone[Title/Abstract] OR telephone[Title/Abstract] OR digital[Title/Abstract] OR online[Title/Abstract] OR internet[Title/Abstract] OR remote[Title/Abstract] OR mobile[Title/Abstract] OR app[Title/Abstract] OR computer[Title/Abstract]) AND (therap*[Title/Abstract] OR intervention[Title/Abstract] OR support[Title/Abstract]) AND (mental[Title/Abstract] OR wellbeing [Title/Abstract] OR psych*[Title/Abstract] OR depress*[Title/Abstract] OR anxi*[Title/Abstract] OR self harm[Title/Abstract] OR suicide*[Title/Abstract])

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