The Door That Never Closes

How digital counselling can enable early intervention

Elaine Bousfield, Founder and Chair, XenZone
Digital counselling is in the right place at the right time

Digital counselling is in the right place at the right time. Though established for over a decade, it now seems to have ‘come of age’ at a time when a lot is being asked of the NHS and as mental health has taken political centre stage.

The Government has pledged to transform mental health support, but with a system under severe strain, transformation will need to be truly visionary and realised urgently. For this to happen, we must look beyond a simple extension of the present system.

The need for early intervention at scale has never been more apparent or urgent

In January 2017, Prime Minister Theresa May gave a speech highlighting mental ill-health in the UK. Describing a package of measures to tackle mental health, she acknowledged that one in four people has a common mental disorder at any one time, and that the economic and social cost of mental illness is £105 billion – similar to the entire annual NHS budget.

The Government also cited figures showing that mental illness disproportionately affects young people, with over half of mental health problems starting by the age of 14 and 75% by 18.

Such shocking statistics are a powerful argument for supporting children and young people in developing the skills they need to navigate through life and all it brings, to help prevent mental health problems emerging or, where they do, reduce escalation.

Local authorities (LAs), foundation trusts and clinical commissioning groups (CCGs) are tasked with finding affordable solutions which can scale to meet this burgeoning need. And this cannot come soon enough. Local authorities are unable to meet increasing demand and high child and adolescent mental health services (CAMHS) thresholds mean children and young people are being refused care.
According to the CentreForum ‘State of the Nation’ report in 2016, on average, CAMHS turns away 23% of children whose parents, GPs, teachers and others have referred for treatment. The report states: “Something has to go drastically wrong before some services will accept a referral; the antithesis of an early intervention approach.”

Often this means that those in need will, in all likelihood, return again to the NHS in crisis. By then, their needs will be greater and they and their families will have suffered unnecessarily in the meantime.

The increase in accident and emergency admissions from those with mental health issues demonstrates this escalation to crisis. Data from NHS Digital shows that between 2011-12 and 2015-16, the number of patients attending A&E units with psychiatric problems had risen by almost 50% to 165,000. Although this figure is a small percentage of overall A&E admissions, it is a wake-up call to policy makers who must invest in better care for children and young people who need not reach crisis.

The rise in the number of children and young people being assigned inpatient care paints a similar picture. The 2014 NHS England CAMHS Tier 4 Report shows inpatient bed numbers had risen from 844 in 1999 to 1,264 in 2014.

Quoting these figures, the CentreForum Commission on Children and Young People’s Mental Health State of the Nation (2016) report said: “The pressure on inpatient provision could be caused by the lack of appropriate care outside the hospital. More investment in community provision would enable early intervention to prevent people reaching crisis point…”

The opportunity to help the 23% currently refused treatment is significant, whether offering children and young people counselling, access to self-help materials, the ability to exchange advice with peers or other specialist support. Such interventions could unburden large parts of the NHS, not to mention prisons and schools, and bring about positive change for a considerable proportion of the population, many of whom would stand to make a complete recovery.

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‘State of the Nation’, CentreForum Commision on Children and Young People’s Mental Health (2016)
The case for early intervention

In his first major early intervention report, ‘Early Intervention: The Next Steps’ (2011), Graham Allen MP analysed the consequences of early and late interventions. The report stated: “Early intervention…offers our country a real opportunity to make lasting improvements in the lives of our children, to forestall many persistent social problems and end their transmission from one generation to the next, and to make long-term savings in public spending.”

The same report explained how health, social and behavioural problems can become rooted: “Delayed intervention increases the cost of providing a remedy for these problems and reduces the likelihood of actually achieving one.”

There are clearly options in the way we tackle the growing problem of mental ill-health and emotional wellbeing in this country. But late, crisis-based intervention has proven to be the least attractive, morally and financially.

And although cost might seem an unsavoury measure, it is vital in quantifying the value of early support. Smart investment in a transformed system would mean better support for children and young people, and the avoidance of greater financial and human costs in the medium and long-term should issues be left to escalate and entrench.

‘The Cost of Late Intervention’ report in 2016 from the Early Intervention Foundation put a price on this ‘entrenchment’. It found that nearly £17 billion per year is spent in England and Wales by the state on the cost of late intervention.

In his second report on early intervention, ‘Smart Investment, Massive Savings’, Graham Allen MP made a similar point, arguing that early intervention reaps “…massive savings in public expenditure for the smallest of investments in better outcomes, and by avoiding expensive provision when things go wrong. By building out the immense costs of failure, it is in fact the best sustainable structural deficit reduction programme available.”

If late intervention is storing up problems for UK public services, then the moral case for early action is just as clear cut.

An early intervention study in 2010 from the Department of Children, Schools and Families argued that early support can break inter-generational cycles of social problems not only in relation to early years development, but also because parents can often be more receptive to support when their child or children are very young.

“Early intervention…offers our country a real opportunity to make lasting improvements in the lives of our children”

Professor Dame Sue Bailey, Chair of the Children & Young People’s Mental Health Coalition, recently wrote that “...a large part of delivering an overall sustainable health service for the future is ensuring that we get children’s mental health services right.”

Getting this end of the mental health spectrum ‘right’ means not only focusing and ring-fencing funds, but importantly re-engineering the system around the needs of the child or young person.

Mental health and schools

While individuals, families and those in the NHS are frustrated by a system that is not providing sufficient early intervention, schools too are feeling the strain. In the Prime Minister’s speech, it was announced that every secondary school would be offered mental health first aid training, teaching school staff how to identify symptoms and help those who may be developing a mental health issue.

The Prime Minister also promised trials to strengthen links between schools and NHS specialist staff. This is welcome news as schools are often on the frontline in dealing with mental health problems.

But while initiatives are welcome, budget cuts continue to bite, with services under intense strain to deliver.

The IPPR’s report in 2016, ‘Education, Education, Mental Health’ argued that there was a ‘perfect storm’, with cuts to early intervention services happening at the same time as rising mental ill-health.

According to the report, “The value of ‘early intervention’ allocation received by local authorities fell from £3.2 billion per year in 2010/11 to £1.4 billion in 2015/16, a reduction of 55 per cent.”
Health and education

The Health and Education Committees in the UK are now examining the role of education in children and young people’s mental health as part of their joint inquiry. They have heard that while all schools intend to provide mental health support for their pupils, only around half provided counselling (and funded it), and in most cases this was only for one day a week or less.

As the Committees consider issues of co-ordination between health and education services, early intervention and prevention and the impact of budget pressures, a report from teenage mental health charity stem4 has found that the vast majority of teenagers are experiencing “emotional distress” after starting secondary school and say teachers do not have the skills to help them.

According to Nihara Krause, a consultant clinical psychologist and founder of stem4: “Young people need better access to early interventions provided by properly trained mental health professionals who can either deal with these problems directly or make referrals to appropriate secondary services.”

Innovative commissioning

Acknowledging that there is an irrefutable case for early intervention does not mean it is not already happening. Halton CCG is a case in point (see page 11). It re-imagined its local mental health service provision, ensuring that young people have an easy way in, and the right support.

Another positive example of integrated CAMHS, providing accessible support for children and young people, was cited in the Education Policy Institute’s 2016 report, ‘Children and Young People’s Mental Health: Time to Deliver’. In the report, Forward Thinking Birmingham is noted for having redesigned its systems to include the Children’s Society in its partnership, and for having shared care records with the Children’s Society’s drop-in centre, Pause.

We see this innovative integrated approach happening in Birmingham, Halton and other LAs, such as Devon, Lincolnshire and Surrey. In the latter, we are part of a truly innovative partnership of 15 national and local voluntary, statutory and private providers working with Surrey & Borders Partnership NHS Foundation Trust.

Unfortunately, these are currently isolated examples and without country-wide availability, few of those in need across society are benefiting. For mental health support to be universally available for all children and young people, however, there needs to be a shift: instead of waiting lists, thresholds, tiered services and complex structures, services should be person-centred and needs-led.
As we said in our 2016 white paper: “Service Without Thresholds”, written in partnership with The Children’s Society, early intervention and ease of access in a transformed system are essential.

Young people, children and families need a simple way in. The individuals and institutions that support them in everyday life – midwives, health practitioners, primary and secondary school teachers, pastoral support staff and carers – need a simple route in too.

This is, in essence, what the 2015 ‘Future in Mind report’ argued for. It acknowledged that we need to move away from a system defined by “organisational boundaries” or in terms of the services organisations provide, to one built around the needs of children, young people and their families.

It maintained that support could be delivered by “joining up services locally through collaborative commissioning approaches between CCGs, local authorities and other partners, enabling all areas to accelerate service transformation.”

All the elements we need to achieve this shift exist already. Visionary CCGs are already transforming their mental health services in this way - and can demonstrate better outcomes as a result.

The NHS recognises this, and believes it can bring about improvements across the board in a number of areas, including offering faster help for people with mental ill-health. Through the Sustainability and Transformation Plans (STPs), the NHS and local councils in 44 areas of England have been charged with outlining their transformative plans for the future, relieving strain on the system through collaboration between organisations.

It is this last point, at least in relation to mental health services, that is key to the success of the STPs: they must show a truly integrated ‘partnership’ approach. This will ensure a collaborative system, which can efficiently and effectively serve the growing numbers of children and young people who need help.
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### The role of digital

Given the evidence for early intervention, and progress towards transformation, it is time to acknowledge the role online counselling and emotional wellbeing services must play in achieving universal service delivery at a time and place to suit the child or young person in need. If we have established that we need easily accessed early intervention at scale, then we must also recognise that most young people are ‘digital natives’, who find it far easier to access a service on their smartphone than waiting to be referred to a traditional service.

Digital services are scalable and access to help is immediate. By removing thresholds, online counselling can reach the 23% of children and young people turned away by CAMHS.

We regularly survey the 34,000 children and young people who use Kooth, with the vast majority consistently telling us they prefer online counselling to face to face (approximately 85%). Young people are comfortable online – even more so knowing they can self-refer and remain anonymous at the point of entry, meaning they do not have to contend with the stigma that may be associated with seeking help.

As Norman Lamb said in the Future in Mind report, “We need to make better use of the voluntary and digital services to fill the gaps in a fragmented system.” Digital services are the first step in such a transformed system. Becoming a hub for young people first seeking help means professional counsellors and emotional wellbeing practitioners can refer out or work within the site to provide instant and ongoing support. The anonymity of the service means more self-referrals and an increase in successful early interventions.

The digital advantage is significant:

- Reduced waiting times
- Reduced waiting lists
- Reduced pressure on GPs, A&E departments and hospitals
- Reduced pressure on specialist services
- Instant, professional stigma-free support for children and young people, whenever and wherever they need it
While the benefits are clear, digital is no silver bullet and cannot – and should not - work in isolation. It cannot bring about an instant transformation or an easy route out for a beleaguered NHS. It will only work effectively when it is integrated with other services.

And that is the point: a transformed system needs digital if it is to meet the needs of children and young people experiencing mental ill-health. At the same time, digital counselling services will operate best when part of an integrated transformed system.

Digital is not the only answer

While Kooth has a 13-year history, digital counselling itself is still in its infancy when it comes to academic evidence. The quest for a methodology for 'hard' research or randomised control trials in online therapy has just begun.

Initial work with academic institutions to gauge the efficacy of online versus face to face therapy, however, has proved positive. According to a 2016 paper, supported by XenZone, in the Journal of Psychologists and Counsellors in Schools, ‘Comparing Online and Face-to-Face Student Counselling’, “Young users report that they find the online environment safe and feel less exposed, confronted and stigmatised.”

Among its conclusions were that: “online counselling has the potential to provide an important support system for issues that might otherwise remain unexplored.”

This was compared to the year prior to the introduction of Kooth, which had seen an 8% increase in referrals.

Commissioner-led research in Lincolnshire found that 89% of children and young people using Kooth said they prefer online counselling to face to face services.

This is certainly borne out by the feedback we receive from some of the children and young people registered on the Kooth site. However, as previously stated, digital is not the only answer. And we are certainly not arguing for online therapy over face to face counselling – indeed, we provide both. Both should be available, according to need. Both can deliver all the benefits of early intervention and both should be integrated with other mental health services.

“Young users report that they find the online environment safe and feel less exposed, confronted and stigmatised.”

‘Comparing Online and Face-to-Face Student Counselling, Journal of Psychologists and Counsellors in Schools (2016)
Schools are an obvious place to start with early intervention. Many schools offer counselling and pastoral support. Some lead the way in establishing good links to mental health services so that teachers have the right guidance to help children and young people get the right support.

Taking such a ‘whole school’ approach means building close ties with teachers and school counsellors.

School-based counselling and emotional support are not add-ons; they should be publicly acknowledged as an important component of our education system.

This includes developing supportive cultures within schools and looking critically at the demands we place on teachers. Emotional health is a crucial achievement, and should be everyone’s business.

And we know an approach like this works. Aside from the positive influence on young people’s lives, there is a strong case for investing in early emotional wellbeing. In 2011, the London School of Economics report ‘Mental Health Promotion and Prevention: The Economic Case’, found that school-based social and emotional learning programmes return £84 for every £1 invested.
The 2015 Future in Mind report demonstrated how the mental health and service delivery models around children and young people were broken and inadequate. Services and systems, it said, needed to be designed around prevention, early help, accessibility and access to specialist support when needed.

There was much ‘wrong’ with the tiered system in CAMHS, where often the thresholds were too high, too inaccessible and encouraged the practice of refusing to support a child or young person, until they became very sick. Often children and young people with safeguarding needs were pushed back to social care, which felt ill-equipped to give the support needed, or back to school for teachers to deal with.

There has, however, been progress since this seminal paper. Out of the thinking leading up to it came the THRIVE framework, which came out of a collaboration of authors from the Anna Freud National Centre for Children and Families and The Tavistock and Portman NHS Foundation Trust.

THRIVE is a working model for many CAMHS areas. It is a way of describing need, which is gauged within five categories: thriving, getting advice, getting help, getting more help and getting risk support. It was a welcome alternative to the ‘tiers’ model.

As discussed, there has also been a greater acknowledgement of the role schools play in supporting its most vulnerable children. We have seen an increase in commissioning of resilience-building work in schools as a result of the Future in Mind report, which fits alongside the Kooth service model as part of a whole school approach.

That said, there is also the recognition that those children and young people who are suffering with mental ill-health – those for example who experience eating disorders, or psychosis or severe depression or/and self-harming behaviours - will need access to specialist support. CAMHS and the NHS continue to have a very important and central role to play, both in treating them and in ensuring that follow up support is in place should they need it. Join up, therefore, is key.
Halton case study

Waiting lists for CAMHS in Halton were high and the system of referrals was not working as it should.

The NHS Halton Clinical Commissioning Group (HCCG) and Halton Borough Council together with the 5 Boroughs NHS Trust, decided to do something different and embarked on a new approach.

The obvious areas to tackle were the long waiting lists and the ineffective referral system.

But, taking a broader view, they decided to start at the beginning: early intervention.

Instead of increasing investment in the tier three crisis services that were so much in demand, HCCG and the Borough Council looked to tier two early intervention services.
Halton case study

Their strategy was to address mental health issues before they had time to escalate. They would focus on reaching out to children rather than waiting for crises to emerge.

And that’s where the partnership approach between the 5 Boroughs NHS Trust and XenZone came in. We began working together on a transformative approach that would support children and young people with their emotional health and wellbeing at the earliest opportunity.

We began by crunching the numbers to establish the right type and level of services needed. Using local JSNA data, combined with research on the number of children and young people who may experience mental health issues appropriate to a response from CAMHS within Halton, meant that estimates could be made as to the level of support young people in the area would need over time.

This research showed that most need would come from tier one and tier two groups - in THRIVE language, the ‘Coping’ and ‘Getting Help’ quadrants. It also showed that most referrals would come from those older than 11.

With this knowledge front of mind, the 5 Boroughs Trust and XenZone began to shape the services and skills needed to support Halton. The service would need a mix of skills, including specialisms around weight management, family therapy, emotional wellbeing support in schools, and counselling (both face to face and online).

These therapeutic services would need to deliver to children from age four to 19, but would also support young people with disabilities and those who are in care or care leavers up to age 25. Group work and a one-to-one programme of support for young people with self-harming behaviours was also included in the system design.

We knew for this collaborative approach to work we needed to work hand-in-glove with a host of skilled partners to build a central point of support for every child or young person in need of help. This would include healthcare professionals, local community groups, charities, social care services, schools, colleges and other education providers, statutory and non-statutory bodies, voluntary, community and faith sector organisations, youth offending services, NHS Hospital Trusts, including A&E, local paediatric wards and liaison services.

It was an ambitious undertaking, but we had to make every effort to link these services. We also needed overarching pathways for referral work, as well as clear signposting and safeguarding protocols.
As a partnership, we agreed that early access was key. We therefore needed to establish:

- A non-stigmatising culture
- A fast, easy way to self-refer
- An easy referral option for professionals
- Self-help and drop-in support
- Different places to get help: school, community, clinic or online
- Short waiting times
- A joined-up team approach so the right intervention could be given at the right time
- Training and consultation for schools

Getting these elements right was crucial in building a mixed model of therapeutic interventions, where children and young people whenever possible, would be given a choice about the type of help they would receive.

We also wanted to see a link from this service to tier three services. Or, in THRIVE language, the ‘getting more help’ and, required specialist face to face help (ie young people with emerging psychosis or an active eating disorder for example), ‘getting more support’ services. To meet this ambition, we redesigned the service to incorporate half a day a week of psychiatry time. This meant that a psychiatrist could support the team or review and advise on any cases we were working with.

Importantly, as part of our joined-up approach, the XenZone and CAMHS teams would be co-located. Tier two services would also use the same processes as tier three, meaning that young people could access all areas of the service without repeating their ‘story’ every time they needed help.

Where are we today?

XenZone has been working closely with 5 Boroughs NHS Trust in Halton for more than two years. Children and young people today are benefitting from the central point of contact for all mental health services.

Those from the age of four and upwards can receive therapeutic one to one work and counselling in school or the community as well as benefit from the other services delivered. Those from age 11 are referring themselves to Kooth anonymously and are using our digital counselling services for free or accessing face to face counselling.

Through Kooth, we offer access to professional online counselling, access to self-help materials and live forums, the opportunity to read or contribute to our online magazine and the ability to leave messages for counsellors at any time. The service is available up to 10pm every day of the year.

In 2016, over 650 individuals logged in to the service to get help. A significant number in Halton use our forums for support; we see discussion threads being accessed on average over 80 times a month.
And 13% of new registrations last quarter were from traditionally hard to reach black and minority ethnic children and young people - a much higher percentage than is typical with face to face counselling, which we also offer. Younger children are getting access to this support in schools, in the community or in clinics, depending on the parent or carer’s choice.

In developing this new one-stop-shop service, we have made schools the cornerstone of our early intervention and prevention strategy. And where we are delivering professional training, equipping frontline staff, parents and children and young people with the skills they need for their own psychological health.

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Has this approach worked?

In a word: yes. Commissioners have observed ‘less noise in the system’. Negative comments from frustrated parents, GPs and schools have reduced. Professionals are finding the service easier to work with and, crucially, children and are being seen much more quickly.

Professionals, such as teachers or GPs are now referring in to this single point. Referrals are assessed and allocated either to psychiatry, psychology or to the co-located team of CAMHS and Kooth. Either way, children are given the right intervention, quickly and without fuss. As a joined-up team, we can refer right across the system according to need.

Use of Kooth’s online counselling service is growing each month. In the last quarter alone, Kooth has been accessed over 600 times by those registered.

To this end, the team is spending time in schools talking to children about the new service. We are holding regular assemblies or workshops on issues affecting the children, from bullying or exam stress, to developing emotional resilience. We also run small group work around self-harm using Dialectical Behaviour Therapy (DBT) skills.

The team is working closely with other professionals, such as social workers and GPs to make sure children and young people know where and how to find help. During 2016, over 450 children and young people registered with Kooth. Most had heard about our service from school (28%), CAMHS (18%) or their GP (14%).

Most are presenting with anxiety or stress, issues around family relationships and friendships – issues that our counsellors are able to support themselves, or through their links with specialist teams. We are still gathering more evidence as to how the whole system is helping, but we can see today that we have done what we set out to achieve. We have reshaped the support offered to young people and driven forward a strategy of early intervention.

This integrated approach, embedding organisations to work together for the benefit of children and young people with tier one and two issues, has transformed waiting times and the process of referrals, which had bogged down the previous system. By building a system to suit the child or young person, rather than expecting them to work round us, we are helping more and more people with mental health problems recover.
XenZone was founded in 2001 to make it easy for all generations to access the best mental health and emotional well-being services as and when they need them. In 2004, we launched Kooth, the first online counselling therapy service for children and young people in the UK.

On Kooth every week...

- Over 400 chat sessions
- Over 2,700 messages exchanged
- Self-help documents accessed over 400 times
- Over 2,000 forum views

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