Orygen
The National Centre of Excellence in Youth Mental Health

Submission

Inquiry into the accessibility and quality of mental health services in rural and remote Australia

11 May 2018

Orygen, The National Centre of Excellence in Youth Mental Health (Orygen) welcomes the opportunity to provide a submission to the Senate Standing Committee on Community Affairs inquiry into the accessibility and quality of mental health services in rural and remote Australia.

About Orygen

Orygen is the world's leading youth mental health organisation, providing cutting-edge research, policy development, innovative clinical services and evidence-based training and education to ensure continuous improvement in the treatments and care provided to young people experiencing mental ill-health. Located in Melbourne, Orygen has over 300 staff working on early intervention for youth mental health for a range of mental health disorders including psychosis (diseases like schizophrenia), anxiety, depression, suicide prevention and self-harm prevention. Orygen's early intervention solutions include functional recovery (getting young people back to work and back to school), online interventions and novel therapies.

Introduction

This submission addresses the issues of accessibility and quality of mental health services in rural and remote Australia as they affect young people aged 12 – 25, specifically. The Young Minds Matter survey found 12.6% of young people aged 4 - 17 from greater capital cities experienced a mental disorder in the previous 12 months, versus 16.2% of persons from other parts of Australia (1). Three out of four young people experiencing a diagnosable mental illness do not access professional mental health care (2).

As this submission will highlight, issues of accessibility can be magnified for young people in the bush due to practical and attitudinal factors.

Orygen consulted members of its Youth Advisory Council and Youth Research Council in the development of this submission for perspectives from young people living or with experience in rural or remote Australia. Two quotations from their feedback are included in this response.

(a) The nature and underlying causes of rural and remote Australians accessing mental health services at a much lower rate;

Issues

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Understanding mental ill-health prevalence and experiences of rural and remote young people

Orygen has raised the issue of a lack of data on youth mental health across a number of policy reports. This includes a lack of information about the prevalence, severity and complexity of mental ill-health among young people and the experiences of young people in help-seeking, including accessing and engaging with mental health services. As a priority, data on access to mental health care for young people in rural and remote areas is required to be able better understand and address the needs of young people in these communities.

Practical barriers to early intervention and primary mental health services for young people

Young people appear to access emergency departments for mental health services at a similar rate, whether in metro, rural and remote areas (3). However, the rates of access of Medicare-subsidised mental health services per population decrease significantly with rurality (4). A lack of early intervention and primary care mental health services is one of the greatest obstacles to accessing quality mental health care in rural and remote Australia.

Distance

In rural and remote areas, the distance to any kind of service, particularly one that caters for youth mental health, can be prohibitive (5). A review of headspace centres following nine rounds of the headspace rollout highlighted that while over 66% of young people in major cities live within a 10-km radius of a headspace centre, as few as 1% of young people in remote Australia live within a 30-km radius of a centre (6). Not surprisingly, most people attending headspace live within 10 km of the centre they attend (7).

Young people under 18 cannot drive themselves to appointments or centres, relying on parents or older friends or relatives to take them (8). Public transportation is often poor or non-existent in rural and remote communities. A reliance on someone else to be able to travel to an appointment raises issues of anonymity, which is already a concern in rural and remote areas where there is a high level of stigma surrounding mental ill-health. A lack of professional services and the need to travel were cited as barriers to help-seeking by 33.6% and 17.5% (respectively) of 11 – 18-year-olds in a study of rural Victorian adolescents (9), while transportation has been identified as an access barrier for young people nationally (6).

Opening times

Opening hours were identified in an independent headspace evaluation as one of the key barriers to accessing youth mental health services (6). Mental health services need to be funded to be able to provide care on weekends and until 9pm on weekdays for improved access and engagement.

Cost

Anecdotally, Orygen is aware of rural youth mental health services operating in areas where the socioeconomic disadvantage is such that many of the young people who attend are also offered basic sanitary kits, tampons and condoms because these items are unaffordable for the population serviced. The cost of travel to a service provider, combined with the possibility that bulk-billed services may not be available within a reasonable distance, can be prohibitive for young people seeking mental health care.

Socioeconomic disadvantage has a cyclical effect, where a downturned economy and unemployment not only limits access to mental health services, but also correlates with mental ill-health. Young people who are not participating in work or study are overrepresented at headspace centres at a rate of two times that of the general population (6). The Young Minds Matter report shows significantly higher prevalence of mental disorders in children and adolescents aged 4 – 17 years old whose parent(s) or carer(s) were not in employment (21.3% in two-parent or carer households compared to 10.8% where employed, and 29.6% in single-parent or carer homes compared to 17% where employed) (1).

Workforce

Extensive wait times to see the few health practitioner(s) available due to a minimal mental health workforce in rural and remote areas contribute to a lack of access by young people. This is discussed further in section C.

Attitudinal barriers to mental health services for young people

Attitudinal barriers, discussed in section E, have a significant impact on access to services in rural and remote Australia.

Recommendations

1. There is an urgent need to improve national data sets with targeted efforts to ensure data reflects the specific mental health experiences of young people in rural and remote Australia. All results gathered should include breakdowns by rurality, and should reflect the data of specific population groups that may be at greater risk of mental ill-health, such as Aboriginal and Torres Strait Islander young people.Service opening times need to enable young people (and their families or carers) to attend without requiring time off of school and/or family member's work.
3. The Australian Government should consider investigating and scoping new models of care, such as outreach and satellite services, technology services and utilising community services (such as schools), that may be able to address the practical barriers currently limiting access to mental health care for young people in rural and remote areas.

(b) The higher rate of suicide in rural and remote Australia;

Issues

High rates of suicide by young people

Suicide was the leading cause of death for 15 – 24 year olds in Australia in 2015 (10). Australian Bureau of Statistics data demonstrates that the rate of intentional self-harm (suicide) resulting in death of children aged 5 – 17 years from 2012 – 2016 was 3.2 outside of greater capital cities, compared with 1.8 in greater capital cities (11). The Young Minds Matter report shows that 12 – 17 year olds outside greater capital cities who had experienced a major depressive disorder showed percentages 6.5% higher for suicide ideation, 13.6% higher for suicide planning, and 9.6% higher for attempting suicide than for those living in greater capital cities (1).

Any plan to address the higher rate of suicide in rural and remote Australia should consider the help-seeking preferences and particular factors of suicide risk for young people within these communities. Stakeholders and young people consulted for the Orygen Raising the Bar report on youth suicide prevention believed current Australian Government suicide prevention activities had not fully considered or addressed these factors and preferences (10). In order to effectively address youth suicide, including for rural and remote young people as a priority population, the Australian Government must commit to the development of a targeted and evidence-based Youth Suicide Prevention Plan in collaboration with young people.

> *"In farming communities, financial strain and resistance to seek help when faced with mental health are the two major contributing factors… This strain felt by farmers is far reaching - as when farmers suffer financially an entire farming community does. Businesses lose customers, schools lose kids, sports teams lose players and a community is left fractured by financial strain and lack of opportunity… The financial strains, pressure of future seasons, lack of community, geographical distance and no desire to access a mental health service, suicide becomes an answer." — Young person*

Suicide clusters

Suicide clusters occur when the rate of suicide per area or unit of time is higher than expected. A study of suicides in Australia from 2010 – 2012 found young people's suicides were more likely to be part of a suicide cluster in time and space than adult suicides, while three out of five suicide clusters of young people occurred in very remote areas (12). Suicides by Aboriginal and Torres Strait Islander young people and adults were both more likely to be part of a suicide cluster than not (12).

Suicide clusters may be caused by a contagion effect, which may be increased in rural and remote areas where the impact of a suicide is widely felt due to the inherent smallness of population.

Unfortunately, current systems do not provide data in time to make a real-time impact in post-discharge and postvention services. Emergency department self-harm presentation and suicide attempt data should be collected from all rural hospitals, and systems linked to coronial investigations for timely data, so that emerging issues such as suicide clusters can be addressed immediately, similar to what occurs for infectious diseases. National, sentinel coordination is required to ensure data is available throughout all rural and remote areas of Australia.

headspace School Support is mobilised when a suicide occurs within a school community. This postvention response, along with suicide prevention activities and direct and safe conversations, is necessary in all primary and secondary schools and tertiary institutions across Australia to help address suicides before a cluster occurs.

Community measures

The community initiatives discussed in section E are important to suicide prevention activities across a community. The Australian Government should facilitate community initiatives through integration across sectors, including establishing cross-portfolio mechanisms in support of a Youth Suicide Prevention Plan that address the needs of vulnerable populations of young people, in particular, those living in rural and remote communities and Aboriginal and Torres Strait Islander young people.

Primary Health Network (PHN) suicide prevention funding should be allocated for youth-specific measures, including connecting with and upskilling community workforces such as in primary care, schools, police and other community services in youth mental health. Other PHN-funded measures should include technology initiatives and community-based postvention activities designed for the needs of the particular rural and remote community.

The data and outcomes emerging from the community-based suicide prevention model trials currently being conducted by 12 PHNs, as well as the data from state-funded trials, will be integral to the implementation of effective models across Australia's rural and remote communities. Orygen notes that only one metropolitan trial site (Perth South) specifically focuses on youth suicide prevention. Youth-specific data and outcomes should be drawn from each trial site in order to effectively address youth suicide prevention across Australia, including in rural and remote areas.

Recommendations

1. A Youth Suicide Prevention Plan that contains a specific focus on priority populations, such as young people living in rural and remote areas, is urgently needed.
2. Sentinel coordination of hospital discharge and coronial investigation data is required for a responsive indication of potential suicide clusters.
3. Continued resourcing for headspace School Support in rural and remote areas, as well as continued support for national crisis service infrastructure, including Lifeline, Kids Helpline and beyondblue, will increase rural and remote youth suicide prevention and postvention.
4. All PHN suicide prevention community-based trial sites should collect specific data demonstrating outcomes for young people to address the higher rates of youth suicide across all parts of Australia, particularly rural and remote regions.

(c) The nature of the mental health workforce;

Issues

Workforce shortages

Health workforce

Workforce shortages are particularly pronounced in Australia's regional, rural and remote areas (13), with 23.2 FTE psychologists per 100 000 population in very remote areas (compared with 102.6 FTE in major cities) (14) and 2.1 FTE psychiatrists (compared with 15.8 FTE in major cities) (15). There are 31.6 FTE mental health nurses employed in very remote areas, compared with 90.4 FTE in major cities (15).

With an already reduced workforce in rural and remote Australia, there are even fewer health professionals that are adept at addressing the mental health issues and common comorbidities that affect young people. This can lead to extensive waitlist times for practitioners that are considered youth-friendly. For example, Orygen is aware of a 9 – 12 month waiting period to see a psychologist considered acceptable to young people in parts of the Gippsland region in Victoria.

Orygen acknowledges the 2018-2019 federal budget announcement for investment in mental health nurses through the Royal Flying Doctors Service. It will be important to gain an understanding of the uptake of these services by young people in rural and remote areas as the program is rolled out.

Workforce shortages are often addressed by a revolving workforce, including locum doctors and nurses. Constantly changing staff makes it difficult for young people in a community to feel consistency or to develop the rapport often needed to broach the subject of mental health.

Peer workforce

In addition to an expanded health workforce, an increased peer workforce in rural and remote Australia is important to help engage young people who may not otherwise seek care. Without replacing clinicians, youth peer workers support young people to make connections and navigate the services available to them. Peer support has been linked to lower hospital 'admission rates and longer community tenure' (16). A rural and remote peer workforce should be scaffolded by professional and supervisory support.

Training the existing workforce

Given the limited number of mental health professionals for the general population in rural and remote areas, the likelihood of a 'youth specialist' is minute. All health practitioners in the bush require training and regular upskilling to ensure they are able to effectively work with young people and to 'implement evidence-based practice in youth mental health care' (2). Improved access to workforce development resources, including online training and appropriate supervision, will help to ensure fidelity of treatments in youth mental health across rural and remote regions.

Community workforce

In addition to the health workforce, other professionals that come into regular contact with young people should be trained in basic mental health knowledge and awareness. With appropriate mental health literacy, school staff, sports coaches, community leaders, juvenile justice workers, social service workers, and alcohol and other drug workers could act as gatekeepers to the health system, and would be helpful in directing young people to seek support for mental, physical and sexual health issues. For example, the Young Minds Matter report found that of children aged 4 – 17 with emotional or behavioural problems, 40.5% were first identified at school (1). School counsellors were found to be particularly important. However, an anecdotal response to Orygen from a young person living in a rural farming community indicates a lack of school counsellors and no engagement on the topic of mental health at primary school.

Spotlight: Live4Life – Macedon Ranges

The Live4Life program is a community-based initiative responding to increased mental ill-health, self-harm and suicide among young people in the region. The local council joined with community

partners and all local secondary schools to deliver targeted and accredited Mental Health First Aid to students, teachers, parents/carers, first-responders and community leaders. The program also develops student Mental Health Ambassadors, who are mentored and trained, and who coordinate events aimed at younger secondary students. Currently, over 10% of the local population have received mental health training through this program, which has been reported as increasing the resilience of the community (17). The Youth Live4Life charity was created out of this program, which now empowers and provides continued support to the Macedon Ranges program as well as programs in two other Victorian communities.

Cultural competency

Cultural competency training is also required to ensure all health professionals and health gatekeepers working in rural and remote regions understand the youth cultures of the regions, and diversity within those cultures. Cultural appropriateness of services was identified as a barrier to help-seeking in an independent headspace evaluation (6).

Telehealth

Telehealth, which is discussed further in section F, can help to service rural and remote areas where there is a lack of appropriate workforce.

Recommendations

1. The Australian Government should continue to increase the rural and remote workforce through incentives and training opportunities that promote regional, rural and remote work to doctors, nurses and allied health practitioners.
2. The Australian Government should give consideration as to how best to recruit and support the peer workforce in rural and remote locations.
3. Professional development and training opportunities are important to upskill the health workforce, as well as other professionals working with young people, to improve the youth mental health literacy of rural and remote communities.

(d) The challenges of delivering mental health services in the regions;

Issues

Outreach and innovative service models

The early intervention and headspace models have been shown to deliver quality mental health care to young people (6). Continued roll out of these models across Australia, including regional and rural Australia, will provide more evidence-based services in range of young people in the bush. headspace has had a large uptake in regional parts of Australia, with 39% of young people utilising the service living in inner and outer regional areas (higher than the proportion of young people across Australia who live in regional areas) (6). However, in more rural and remote areas, the thin spread of workforce and vast distances can affect the fidelity of the models. Parts of Australia may not have the population size or workforce to set up full services, particularly those that cater to moderate to severe mental health needs. These areas may be better served by funding effective outreach and satellite services.

There is currently further work needed to understand if some of the evidence-based models that have been trialled in urban areas can be translated with the same fidelity in rural and remote areas. Some outreach clinics have had success in facilitating access to youth mental health services by Aboriginal and Torres Strait Islander young people, young people accessing alcohol and other drug services and young people experiencing homelessness (18). An independent headspace evaluation found headspace staff identified outreach services to be a 'strategy for enhancing headspace services' (6).

Funding is needed for research, development and assessment of outreach and satellite models intended to optimise delivery of care within the resources available. This data will highlight the effectiveness of an outreach or satellite service in comparison to population size, spread and characteristics.

Spotlight – South Gippsland and Bass Coast

Researchers at Orygen are currently undertaking a study funded by the Gippsland PHN to investigate four separate small clinics that work together to cater to youth mental, physical and sexual health and drug and alcohol use as the South Coast Youth Clinic Partnership. They are run by local GPs or practice nurses at medical centres, schools, and a community arts centre, and provide much needed services in areas where there are otherwise none (19). This research should help Orygen and the Gippsland PHN to better understand how the services came into existence, who the young people are that attend these services and how the services have made themselves sustainable.

The Australian Government should consider funding research into rural and remote service delivery, and should work to co-design services in these regions with young people to ensure their access and acceptability.

Systems approach

While the youth mental health workforce is limited in rural and remote areas, other professionals who work with young people can act as mental health gatekeepers, as discussed in section C. PHNs and Local Hospital Networks (LHNs) should be involved in coordinating these services from a mental health point of view, as they may be best placed to understand the needs of the local region and to help different services collaborate, rather than operate in a disjointed fashion. The Australian Government should lead this initiative and ensure any programs used across systems are based on evidence. Orygen would be well placed to provide technical advice and support on the development of resources to support a systemic model that meets the mental health needs of young people.

Recommendations

1. The Australian Government should fund research, development and evaluation of service delivery models that would be effective in rural and remote areas, including small outreach and satellite services and other innovative models across rural and remote communities. There should be a focus on how these models can augment the current national youth mental health platform headspace and evidence-based early intervention services.
2. The federal, state and territory governments should guide PHNs and LHNs to coordinate evidence-based systems approaches to youth mental health across rural and remote communities.

(e) Attitudes towards mental health services;

Issues

Acceptability of services – preference data

The acceptability of a service is crucial to access by young people in any environment, including rural and remote locations. Services that appeal to adults and older people may not be considered acceptable from a youth perspective. A study of young people in rural Victoria aged 11 – 18 years old and living in areas of moderate rurality showed a preference for seeking help for a mental health issue from a school counsellor over any other professional (54.5% of young people surveyed, with 29% listing school counsellor as their first choice) (9). Top reasons given for young peoples' first preferences included: 'prior positive experiences or an existing rapport' (46.4%), a 'belief that the professional was competent and appropriately qualified to help them' (27.8%) and the 'convenience of the professional's location' (17.8%) (9).

Further research is necessary to understand young people's preferences and attitudes in rural and remote areas across the whole of Australia.

The nature of small-knit communities results in members of the community often knowing the local health worker in a personal, social or family context. This dual-relationship or the potential for it can be a barrier for young people from seeking help, as it may give rise to concerns about confidentiality or judgement. There is a need for an increased understanding among rural young people and communities of confidentiality in a health care context, including that confidentiality is important to establishing the therapeutic relationship and that there can be limits to confidentiality (20).

Community initiatives to improve mental health literacy and decrease stigma

The fear of judgement or gossip was identified by 32.1% of rural Victorian adolescents aged 11 – 18 when asked about barriers to seeking professional health for a mental health issue (9). Social exclusion, stigma and gossip throughout a community about all mental health disorders except substance abuse disorders was a theme for rural Victorian high schoolers in a separate study looking at barriers to help-seeking (8). Stigma may be more confronting in small communities where there is a higher likelihood of others becoming aware of a young person's attendance at a headspace or other mental health service, even by simply seeing the young person enter the service (6).

Rural and remote Australia's culture of stoicism, resilience and self-sufficiency have been suggested in studies and through Orygen's engagement with young people as a contributor to stigma and an additional barrier to help-seeking (8).

> *"As country kids, you grow up to be self-sufficient and extremely resilient. You learn to deal with problems on your own and not to complain." — Young person*

A study showed some rural young Victorians who advised they would not seek professional help for mental ill-health (44.3% of total respondents), were willing to seek help from their community, including friends (57%) and family (43.8%) (9). Family members have been shown to provide 'emotional support, discussion and encouragement' for young people attending headspace (6). Efforts to address stigma in rural and remote communities should include addressing the mental health literacy of families, as they offer critical support in helping young people feel comfortable accessing services.

As discussed in section C, improved knowledge and collaboration with all areas of the community, including schools, sports, and social services may help community members to identify mental ill-health, including risk of early psychosis (21).

Specific populations

There are specific populations of young people which may have increased prevalence of mental ill-health in rural and remote Australia, such as Aboriginal and Torres Strait Islander young people, LGBTIQ young people, culturally and linguistically diverse (CALD) young people, and young men. For example, young men aged 15 – 29 living outside of major cities have an identified increased rate of suicide that is nearly two times the rate inside major cities (22).

These populations may also have distinct help-seeking preferences and attitudes towards mental health services. For example, the independent headspace evaluation found that one-third of staff interviewed thought headspace services required improved 'engagement practices with Aboriginal young people' (6). Many mental health services that do not focus on a person's whole social and emotional wellbeing are not seen as culturally appropriate for Aboriginal young people (23). This is a significant reason for an Aboriginal young person's lower likelihood of engagement, but higher likelihood to require acute inpatient care (24). Further research is needed into the impact of norms on the health and help-seeking preferences of these population groups. Guidelines produced should be evidence-based and developed with direct input from young people in these population groups.

Recommendations

1. The Australian Government should consider funding research into the help-seeking preferences and attitudes of young people in rural and remote regions across Australia. Funding should cover research into reasons for rural and remote young people not seeking help and reasons for quick disengagement from services
2. Targeted funding for the development, implementation and evaluation of innovative services co-designed with young people is necessary to increase access to youth mental health services in the bush.
3. The Australian Government should address the culture of stigma towards mental ill-health in rural and remote regions by improving mental health literacy in families and communities.
4. In order to effectively engage the young people in their catchment, PHNs need to understand the specific local populations, such as refugee populations or Aboriginal and Torres Strait Islander populations. After a needs assessment, targeted efforts should be used to design services that meet the needs of the local population. Efforts should include working in partnership with young people from the area who are members of local population groups.

(f) Opportunities that technology presents for improved service delivery; and

Issues

Technology platforms present a means to help solve some of the mental health access issues facing young people in rural and remote communities by providing services where none exist. There are many opportunities for technology; however, Orygen remains cognisant that technology cannot be a replacement for face-to-face services, particularly while real and extensive internet connectivity hindrances exist.

Information access on mental health supports

Access to online information about mental health is important, particularly if a young person faces stigma in their help-seeking. The Australian Government has pulled together a set of 'Teleweb' resources to benefit people experiencing 'mild to moderate mental disorders… and particularly those people in rural and remote areas who face barriers in accessing face-to-face services' (25). While this is a helpful informational resource, there is little evidence that existing online platforms are being accessed by and benefiting a greater proportion of people in rural and remote communities, including young people.

The Australian Government's Head to Health website, intended to provide low-level support for mild mental health presentations, should be reviewed to better understand who is using it and their experiences with it. The website should add value to young people in their engagement with support and services online through: age-appropriate youth interface, connections to available face-to-face mental health services and suicide prevention initiatives of the user's local PHN, and measures to address existing gaps in cultural and language barriers to help-seeking. The information provided should include opportunities for care, including telehealth options and how to engage in them. Online information services should seek to translate into help-seeking behaviours. Any upgrades and updates to the website should be co-designed with young people from rural and remote communities in order to facilitate uptake of this resource by this population.

Quality care delivery

Telehealth

Medicare Benefits Schedule (MBS) data for all medical telehealth claims processed by mid-2016 demonstrate that 45.4% of services were used by consumers in outer regional, remote or very remote areas (26).

In relation to mental health specifically, the Australian Government has recently increased access to psychological services for rural and remote young people, enabling seven of 10 Better Access services provided by psychologists or other allied health workers to be accessed via telehealth (27). However, access may be severely hindered by the requirement for a consumer, who must be located in Modified Monash Medical areas 4 – 7, to meet with the particular provider face-to-face during one of their first four sessions. In reality, this MBS measure may do little to ease the burden on health professionals already working in rural and remote regions. The Australian Government should investigate usage and outcome data by rurality to identify the impact of this new initiative.

Other practical issues may make telehealth more difficult for young people in rural and remote communities, in particular, any requirement to have a health professional on location, and any requirements restricting the video communications to be completed at a health facility that does not offer extended hours. As telehealth relies on streaming video services, any internet infrastructure difficulties will also hinder access to telehealth in the region.

Tele-case conferencing

Telehealth case conferencing may be a critical part of care for young people with chronic and complex mental ill-health in rural and remote areas. However, the MBS only supports case conferencing that includes a GP (28). Limiting case conferencing item numbers to those with a GP excludes young people in rural and remote areas where there is limited GP access, even though an Aboriginal Health Worker or primary care nurse may be providing care to them.

Therapeutic intervention services

Online therapeutic services are ideally used in connection with face-to-face care, rather than as a replacement (29). They may also be used more readily by young people who are already engaged in mental health care rather than improving engagement with people who do not seek face-to-face help. Funding for new technologies is important, but should not be to the detriment of funding in-person services.

Web-based services, such as eheadspace and Kids Helpline, provide links to online health practitioners for young people in rural and remote areas; however, usage data indicates that they are mainly used by young people in metropolitan areas. For example:

- A review of eheadspace clients demonstrated that 7.5% of young users lived in outer regional areas (compared to an 8.8% population spread) and 0.9% of young users lived in remote or very remote areas (compared to a 2.2% population spread) (7). While the rates of use are not far off the total percentage of population, they do not demonstrate the increased engagement in rural and remote areas that may have been expected from the provision of mental health services online.
- Kids Helpline Statistical Summaries reveal that of contacts from 5-25-year olds with known levels of rurality,[1] 72% were from major cities, 20% were from inner regional areas and 8% of contacts were from outer regional/remote areas (per the Australian Statistical Geography Standard) (30). Phone contacts were also found to be more frequently used by young people in outer regional and remote areas, while web chat usage was more frequent for young people in major cities (30).

In order for new technologies to help address rates of access in rural and remote communities, there needs to be an understanding of why young people in rural and remote areas are not engaging in the current services available. Research into this will be critical to provide more effective services through technology in the future, as will the involvement of young people in the design and development of

[1] Kids Helpline rurality information was only known for approximately 34% of contacts.

online mental health services, to ensure they are appropriate, acceptable and accessible for this age group.

Functional recovery

Functional recovery is an integral part of youth mental health care to help reduce the risk of relapse. However, rural aftercare is often completely separated from acute inpatient care, particularly if the young person travelled long distances to a metropolitan area to receive acute care. Technology platforms, such as Orygen's Moderated Online Social Therapy (MOST) platform, can help to aid full functional recovery through online evidence-based therapy and social media moderated by online clinicians.

MOST delivers professional support, peer-to-peer social networking, and interactive comic-based therapy modules in an integrated online platform that is accessible at any time and from any location with internet connectivity. To date, Orygen has undertaken 16 research trials that have disseminated 10 interventions to hundreds of young people online, including those in rural and remote communities. A recent trial offered MOST to young people seeking support for emotional distress, 28.4% of whom lived in rural areas and 2% of whom lived in remote locations. Preliminary results indicate significant reductions in depression and loneliness during participants' involvement in the trial. Platforms such as MOST may play a role in facilitating functional recovery for its users, and have potential to benefit young people in rural and remote communities that cannot easily access face-to-face recovery supports. Further research is needed to validate engagement with and the effectiveness of online therapeutic approaches for young people, including young people in rural and remote communities.

Recommendations

1. Funding towards technology services should be in addition to, rather than in place of, funding for face-to-face services.
2. Measurable outcomes for young people should be a focus for all online platforms. Evaluation of new technologies, including the Australian Government Head to Health website, is important to better understand what works and what does not work to engage young people in mental health care online, and why young people in rural and remote areas are not engaging in available online interventions at an increased rate. All updates and new platforms should be co-designed with young people from targeted communities, such as rural and remote areas, to increase engagement.
3. If not already doing so, the Australian Government should measure usage and outcome data for telehealth and tele-case conferencing by rurality to be able to improve the service structure as necessary.
4. The Government should continue to help fund platforms such as eheadspace, Kids Helpline and MOST in trialling, delivering and evaluating evidence-based therapy and recovery services, as these platforms have the potential to improve upon the care and recovery services available for young people in rural and remote communities.

Further information

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References

1. Lawrence D, Johnson S, Hafekost J, Boterhoven de Haan K, Sawyer M, Ainley J, et al. The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter). Canberra: Department of Health August 2015.

2. Freijser L, Brooks P. Addressing Workforce Challenges for Youth Mental Health Reform. Parkville VIC: Orygen Youth Health Research Centre; 2013 March 2013.

3. Hiscock H, Neely R, Lei S, Freed G. Paediatric mental and physical health presentations to emergency departments, Victoria, 2008-15. The Medical journal of Australia. 2018.

4. National Rural Health Alliance Ltd. The little book of rural health numbers. November 2015 Edition ed2017.

5. Brown A, Rice SM, Rickwood DJ, Parker AG. Systematic review of barriers and facilitators to accessing and engaging with mental health care among at-risk young people. Asia-Pacific Psychiatry. 2016;8(1):3-22.

6. Hilferty F, Cassells R, Muir K, Duncan A, Christensen D, Mitrou F, et al. Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program. Sydney: Social Policy Research Centre UNSW; 2015.

7. Rickwood D, Webb M, Kennedy V, Telford N. Who Are the Young People Choosing Web-based Mental Health Support? Findings From the Implementation of Australia's National Web-based Youth Mental Health Service, eheadspace. JMIR Mental Health. 2016;3(3):e40-e.

8. Francis K, Boyd C, Aisbett D, Newnham K, Newnham K. Rural adolescents' attitudes to seeking help for mental health problems. Youth Studies Australia. 2006;25(4):42.

9. Boyd C, Hayes L, Nurse S, Aisbett D, Francis K, Newnham K, et al. Preferences and intention of rural adolescents toward seeking help for mental health problems. Rural Remote Health. 2011;11(1):1582.

10. Robinson J, Bailey E, Browne V, Cox G, Hooper C. Raising the bar for youth suicide prevention. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2016.

11. Australian Government. 3303.0 - Causes of Death, Australia, 2016. In: Australian Bureau of Statistics, editor. Canberra: Australian Bureau of Statistics,; 2017.

12. Robinson J, Too LS, Pirkis J, Spittal MJ. Spatial suicide clusters in Australia between 2010 and 2012: a comparison of cluster and non-cluster among young people and adults. BMC PSYCHIATRY. 2016;16.

13. Carbone S, Rickwood D, Tanti C. Workforce shortages and their impact on Australian youth mental health service reform. Advances in Mental Health. 2011;10(1):92-7.

14. Australian Institute of Health and Welfare. Allied health workforce 2012. Canberra: AIHW; 2013. Contract No.: no. 5.

15. Australian Institute of Health and Welfare. Mental health services in Australia: Mental health workforce 2018 [updated 3 May 2018. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-workforce.

16. Repper J, Carter T. A review of the literature on peer support in mental health services. Journal of mental health. 2011;20(4):392-411.

17. Youth Live4Life. FAQs: What is the evidence that the model works? 2018 [Available from: http://www.live4life.org.au/faqs/.

18. Rickwood D, Telford N, Mazzer K, Anile G, Thomas K, Parker A, et al. Service innovation project component 2: Social inclusion model development study. 2015.

19. South Coast Youth Clinic Partnership. South Coast Youth Clinic Partnership 2018 [Available from: http://www.southcoastyouthclinics.com.au/.

20.Lyons A. Mind the gap. Good Practice. 2017(1-2).

21.Welch M, Welch T. Early Psychosis in Rural Areas. Australian & New Zealand Journal of Psychiatry. 2007;41(6):485-94.

22.National Rural Health Alliance Inc. Mental Health in Rural and Remote Australia. 2017.

23.Australian Indigenous HealthInfoNet. Social and Emotional Wellbeing WA: Australian Indigenous HealthInfoNet; [Available from: https://healthinfonet.ecu.edu.au/learn/health-topics/social-and-emotional-wellbeing/.

24.Lewis-Affleck J. Literature review into service model approaches to youth mental health issues in regional areas. In: Consulting E, editor.: Anglicare WA; 2017.

25.Australian Government. Teleweb: Department of Health; 2017 [updated 16 March 2017. Available from: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-teleweb.

26.Australian Government. Telehealth quarterly statistics update: Department of Health; 2016 [updated 24 August 2016. Available from: http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-factsheet-stats.

27.Australian Government. Better access to mental health care: fact sheet for professionals. In: Health Do, editor. 2017.

28.Australian Government. Multidisciplinary case conferences: Department of Health; 2013 [updated 6 December 2013. Available from: http://www.health.gov.au/internet/main/publishing.nsf/content/mbsprimarycare-caseconf-factsheet.htm.

29.Fraser S, Randell A, DeSilva S, Parker A. E-mental health: the future of youth mental health? Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health; 2016.

30.yourtown. Kids Helpline Insights 2016: National Statistical Overview. Brisbane; 2017.