Ian Hickie:

Welcome. I'm Professor Ian Hickie, and I'm from the Brain and Mind Centre, where I'm the Co-director of health and policy. This is now the third in the series of our webinar series titled flip the clinic. Most people will be well aware that our lives have been radically transformed in the last eight weeks by the arrival of the COVID-19 virus, as fundamental transformation in all of our lives economically, socially, and particularly in health services, and the extent to which we've really needed to take onboard new ways of delivering services. Now, it was thought remarkable that we should have this transformation to tele-health and I can actually use the telephone or telephony for the first time in association with Australia's Medicare system. I don't think what people were well aware of was the extent to which digital health and digital health developments were actually taking place across Australia and the extent to which is Australia has been the leader in that area. And issue we have discussed in the first seminar series in terms of the breadth and depth and challenges that actually delivering digital mental health services involves. In our second seminar, we address the issues about how it relates to health systems and may inform health systems and their organization in practice. One of the issues that was highlighted initially, and has come back repeatedly, is the area specifically of Youth Mental Health. In modelling that we released in the last two weeks, and we discussed again last week, the issue of what and well may happen in the face of the economic and social dislocation that we face in Australia, may well unfortunately have its biggest impact on young people. And the area of reducing that impact may well rely on our capacity to actually connect with young people in a variety of settings who may be in trouble, and often the appropriate support and services that they actually require. So this third seminar now is focused specifically on Youth Mental Health, and brings a number of leaders in the area who have been involved in developing relevant in depth programs with strong research and development, strong searches for answers, but also close monitoring of where there are unexpected adverse events, or what issues need to be addressed if these challenges are really to be met, on an ongoing basis.

As we start, I just like to acknowledge the traditional owners of the land which the University of Sydney at least its Camperdown campus is based, who are the Gadigal people of the Eora nation. In fact, much of the work and much of the work that I've been discussing in the public domain with many others over the last few weeks is about the social and emotional well-being of our communities. And there is still much to learn from the traditional owners of this land in the way that we might adapt appropriately to the challenges that we face as a community.

I just like to show you some data from in fact, our own work with young people using the Innowell platform. If we just go forward in the slides, in addressing the concerns of young people. A lot of discussion continues to arise about, you know, do people really go online to look for information? And do they really go to look to these young people, particularly young people? Well, basically, in the surveys that we've been exposed to in long periods of time, overwhelmingly, yes. People, young Australians and young Australians with major mental health problems go where they know to go, go into clinics is unusual, going online is absolutely typical. And finding tools and starting that journey, independent of clinicians. Funny thing to say to clinicians, actually, people have sought help long before they came anywhere near you, and particularly young people this has been going on for a long time and work we were doing previously the for the young and well CRC this has been going on for well over a decade in Australia very actively. And so just to give you some idea of the projects, we've been involved in the Project Synergy in recent times, evolving over 1500, young people, despite what many people say, actually are quite happy to provide a lot of information online and to spend quite a lot of time provided information, if it leads to better health care, and actually, to make use of apps and tools as part of their overall health plan. This is just one example. And I want to talk further about our particular work in this area, because I have the pleasure to not have many other people who've been doing lots of really good things for a long time at different interfaces. And the first group I'd like to move on to is Professor Joe Robinson, and Zoe Teh ups. No, I almost skipped over there. One

of my favourite people, Sam hockey, who was a national health commissioner along with me, but as you can see considerably younger and more attractive than myself, just to say a few words about his work in particular your era and the use of digital tools over to you, Sam.

Sam Hockey:

I'd like to start by acknowledging those people tuned in with lived experience of mental ill health or suicide. I'd like to extend that to those bereaving loss through suicide also. Now more than ever, we have seen the impact technology has had in keeping us connected. We see the benefits of technology in continuing our social connections while we're physically distancing. Although tiresome at times the abilities of connection that technology has provided a revolutionising our healthcare delivery. This is not just happening in the real time modelling of how communities are accessing mental health services and adjusting at apply. But so importantly, delivering care and support that is targeted to the individual and not just the generalized demographic. I'm very thankful to have had access to this kind of revolutionized care in this pandemic. Briefly weekly check ins have provided me with the strength and focus I don't believe I would have otherwise had in a time when both have been tested. Having grown up rurally had I had this kind of access to high quality mental health care. I don't believe I and all my family would have suffered for as long as we did. These have been scary times we've faced as a community times of deep uncertainty. Technology isn't always the answer, but it has proven to be something worth harnessing for our benefit. We acknowledge that technology is not a replacement, but rather it is an enhancement for our connections in life.

Ian Hickie:

I must say I'm incredibly grateful to Sam and the work that he's done in association not just with Project Synergy with Innowell, but he's worked through the National Mental Health Commission as we highlighted in the first seminar his ongoing work with national standards and safety in this particular area, but his own experiences in this South Coast of New South Wales, about lack of care relying on clinics. And the use of care now in the disruptive world, I think is instructive.

In their particular areas that were really keen, Jo Robinson and Zoe Teh address, is the work of Orygen and a particular work within credibly innovative program, in terms of chat safe. One of the things that gets said to me all the time, including this week, if I had the hair I'd pull it out, is we can't discuss suicide because somehow we're going to make people do it if we talk about it. And secondly, for God's sake, you can't discuss it with young people. And you can't combine technology with young people with suicide or the sky will fall in, in a particular way will be causing people, young people to use these two bad things, discussion of suicide and technology to make the situation worse. So I really want to start by asking Joe Robinson and Zoe Teh to co-present their work to address these fundamental myths. Like all great myths they seem hard to kill, as to where the reality really is over to you, Joe and Zoe.

Joe Robinson

Thanks Ian. So, yes, so that's the perfect segue into the chat safe project. So really this project came about because in our work with young people, what we've been hearing from them is that social media provided a really important platform for them to talk about difficult feelings like suicide. But again, as you rightly said, the dominant narrative of the time has really been that we worry a lot about the way young people talk about suicide on social media platforms, because we're afraid that they might cause harm. So for example, we worry that that content might be distressing, or we worried that it

might lead to imitative type behaviour from others. But what we do know is that that social Media has a whole suite or a whole raft of benefits for young people when it comes to seeking help. So it's available 24 hours, seven days a week in the way that clinical services or not, and so on. So there was a whole suite of benefits that we wanted to harness from social media, while mitigating some of the potential risks. So we set about developing the chat safe guidelines, which were evidence based guidelines. And hopefully you can see the reference at the bottom there to prove that I'm not making that up. We did a rigorous piece of research in terms of developing the guidelines. And we then worked with young people from across Australia to bring them to life through a national social media campaign. And this was quite a controversial project when we started out a couple of years ago. And I'll talk a little bit about the chat safe work. But what we really want to do now is pose the questions. Given the success of the chat safe content, given the safety that we've shown, you know, that we've shown it's a safe intervention. Could it be used as part of a real time response following a youth suicide? suicide attempt? and could it be used as a soft entry point into clinical care. And Zoe will talk a little bit more about that. So if we could have the next slide, please Thank you. So this is sort of how the guidelines are structured. They're really structured around the ways in which young people told us they use social media to talk about suicide. So they use it perhaps to share their own thoughts or experiences of feeling suicidal, they might use it to respond to somebody who's suicidal, a friend or a peer somebody in their social network, and they might use it to talk about or memorialize somebody who's died by suicide. So we've structured the guidelines around that content. You can see them they're freely available on the Orygen website. And, and they fall into these different sections. But we really wanted to give young people tools and tips and tricks for them to use when talking about suicide on social media. We wanted to give them the agency to have these conversations safely and not do what other people have been doing, which was try and shut those conversations down. So we really were at pains to give them some practical examples of, for example, language they could use if they saw content that indicated that they might be worried about a friend. So we actually gave them language to use to say, I'm worried about you, I saw your post. Are you okay? Do you feel suicidal? If so I'm here to talk to, for you to talk to. We really wanted to give them model ways that they could have these conversations safely. So the guidelines have been available, they were transformed into a website. As I say, they're all freely available on the Orygen and chat safe website. And we're terribly proud of them. They're a world first and they've been downloaded about 40,000 times they've been translated into 11 different languages, and we're terribly proud of them. But young people don't always access websites always read long sets of guidelines, even though we think they're fantastic. So if we could see the next slide. The next activity we did was bringing these guidelines to life via co-design and co-created social media campaign with almost about 300 young people from across Australia. Again, we went very carefully because we were worried that we didn't want to do harm. We didn't want this content and this activity to be distressing to young people. So we evaluated it as we did it. And we found not only was it not distressing for young people to take part in this project, but they actually learned a lot along the way, they found it beneficial. They felt better skilled and better equipped at talking safely about suicide on social media. And they felt better able to help their friends in their on and offline worlds when they were expressing suicide risk. So we had a whole suite of co-design workshops. And if we could have the next slide, what you'll get a sense of is what some of the social media content looks like. So you can see there on the on one side, it's my right hand side of the slide is an example of the Instagram grid, or the Instagram feed and you can see the content that the young people designed was a mixture of animations of real life young people engaging with our content, and some text based messaging around how to bring the guidelines to life, how actually to talk safely about suicide on different social media platforms. And you can see from the slide, we one way or another, we reach nearly 4 million people. Through the campaign, we had a 12 week campaign, we spent probably about $20,000 on advertising, not on content, but on advertising and pushing the content out. We had around 40,000 downloads of our guidelines. And as you can see, Instagram, Facebook and Snapchat were probably our best performing channels, in particular Instagram stories, and videos were the most favourite format that we use. So we were really using the types of way of

communicating that young people wanted and told us they will want they wanted. Interestingly, we were able to reach equal numbers of males and females and we know if we're thinking about how we might use this as a soft entry point into clinical care, it's often hard to get men to interact with clinical care and to seek help. But we found that men responded quite well to this because they very much found it a soft entry, it was non confronting, they could look at the content without really feeling like it was mental health related content. And the guidelines now sit on the Facebook Safety Center. Facebook and Instagram have been key partners in this project. And the guidelines also sit on their safety center. And we've got a new Instagram guide that was just launched this week. So we really did you know, even though I say it myself, we do quite a good job of bedding this down into the sorts of platforms where young people are already hanging out. So that brings me to one of the next questions, which is that's all well and good. But how might we use social media to be part of a real time response to young people who, you know, following a suicide, so if we could move to that next slide, I realize I'm talking quite quickly. But we know that young people who have been exposed to a suicide are significantly greater risk of further suicidal behaviour as a result of that exposure to a suicide. And you can see that from some work that we've got going on at the moment. So we are now proposing a piece of work where we use the success a we kind of capitalize on the success of the chat safe project, the fact that we've been able to reach so many people so quickly at relatively little cost, that if we were to be notified or at chat safe of a suicide in real time, we could then target professionals with resources that we've already developed. As you can see here, we've got them available on our website. We could target resources to professionals, for example, PHN's, in that region in real time, but we could also target young people who have been, you know, exposed to that suicide with co-designed and evidence based content, designed to help them talk safely about the death of their friend, support each other, access care and memorialize their friend in a safe and supportive way. So we think so we're just piloting and developing and piloting this content now in a very contained way. But the next step for this will be to look at how we might roll this out, in partnership with Department of Health and Human Services, PHN's, and so on to be part of a real time response to mitigate the risk of further suicides, and suicide clusters. So at this point, what I might do is move to the next slide and hand over to Zoe, who will talk about how we might learn from all this to then connect people into clinical care. So over to you Zoe.

Ian Hickie:

Just before we go to Zoe, I just wanted to point people can use Q&A function. I should have said this at the start, of course, the q&a function at the bottom of the screen if they want to put questions to the individual presenters or just in general, I'll try and answer as many as I can, not that I know very much or direct to the people who do really know things as we go. So feel free to use the q&a function at the bottom. Over to Zoe

Zoe Teh:

Thanks Ian. So we know that a lot of young people who are at risk don't seek help, you know, often this that stigma and the shame and as well as cost. But we do know from our chat safe social media campaigns so far, was that a lot of young people do seek online care and support and they often reach out to one another using social media. We know from the chat safe social media campaign that we were able to reach about 4 million young people all across Australia. And this it even costs tclose to about $20,000 for us to achieve as well. So it was pretty, it was quite cost effective. And a lot of young people said that they liked how the information was very generic, it was very digestible, and it was very general, so it wasn't triggering. And a lot of them also reported learning something new. For example, learning how to use the right leg language or knowing how to support someone who they think are in distress. And so I suppose the next way we can try and use chat safe is to, again, like what

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Joe mentioned before, use it as a soft entry point into accessing clinical help, or accessing other online tools that evidence base, that are tested and safe to use as well. If we go to the next slide.

And yeah, so the main take home messages that we've learned so far is that it is safe to talk about suicide, say online, and that social media can be used to reach a lot of young people very quickly. And it's also famously known nowadays, young people are definitely over awareness raising campaigns, you know, we want to see something that's actionable. We want to see something being done. We're tired of hearing the same words over and over again and we want to actually see resources, tools and support that actually are affordable and accessible online. And we also know that social media can be used as a real time response following suicide within a community, and that it is safe to do that. And yeah, campaigns such as chat safe can also be used as a nice soft introduction, I guess, into clinical care. And as Joe mentioned before, check safe is now gone global. So obviously, this need is not just the need for resources online. It's not just in Australia, but it's International. We've had international partners, asking us for chat safe to, you know, go to their country, and to support them as well. So yeah, that concludes the chat safe segment of tonight's webinar. I'd like to thank our funders here as well. Back to you Ian.

Ian Hickie:

Thank you Zoe, and thank you Zoe she is a young person has been involved in this with Joe directly and all the other young people at Orygen have been involved in this kind of work. I think Orygen for many years has demonstrated the reality of co-design and engagement of young people right across their clinical programs. So while we're on the subject of Orygen, we're going to go across to Professor Mario Alvarez in just a second and ask him to talk about the work that he's been involved with the particular, the most program. In the first seminar Norman Swan our facilitator raised the point , " ah this web stuff, this digital stuff isn't just for people who've got a little bit of anxiety, a little bit of depression, who can just self manage, it's not really relevant to people who've gotten really complex mental health problems or significant mental health problems". So that's one issue Mario I want you to really answer. The second one was the complementarity to traditional clinical services and the capacity to which these systems may expand both the peer and clinical access and other ways in which the clinical system may be enriched by the use of these programs on an ongoing issues, both issues that I know your program has addressed in great detail. So, in the next seven minutes, if you wouldn't mind dispelling a few other myths as you go, that'd be great. Mario.

Mario Alvarez:
 No worries. Thank you very much here. It's a pleasure to be here, talking about our work as some of the key areas that we'll be mentioning. So, I direct our Orygen what we call at Orygen the digital division of our organization, looking at digital technologies as a means to enhance Youth Mental Health Services at different levels. And the reason we jumped into technology is because we have recognized a number of key issues and challenges that we face in youth mental health, I put some of these ones here, for example, we know that the vast majority of young people and their families are suffering from mental ill health won't have access to evidence based care. But also even when young people will access treatment we know that our interventions are not compelling enough. 40% of young people only attend one or two sessions for psychological treatment and at the other end 18% get these get discharged s because they run out of sessions, we also know that our interventions are not particularly effective at addressing some key issues for young people such as getting a job or being more socially connected. But even at this end as well, even when young people access treatment, and they get better, we can only provide limited support. And we know that around 80% of young people with mental ill health are going to treat , depression actually complex depression and psychosis will go on to experience relapses for their mental health conditions. And I've got one thing in there as well just to

highlight that to make things worse, which is research translation is really poor in mental health and in physical health in general with a 17 year delay. This is in terms of research being implemented in clinical practice, and even then 85% of findings other methods of clinical practice. So next slide please. So over at Orygen our model is to address these issues by combining persuasive social and humane technology. By that I mean ethical technology with evidence based and novel psychological models, together with computational technologies, such as AI and machine learning, to develop new interventions, and this is really important for us that address key gaps in our continuous mental health, but also that integrate with an enhanced Youth Mental Health Services. So next slide. And our vision is to create interventions at all levels from help seeking, and helping young people to obtain immediate support in terms of Nate through to blended models of care, as Ian was mentioning before that digital interventions that enhance face to face care as well through to digital interventions designed to maintain the hard worn clinical gains of face to face interventions as well, closing the entire cycle and experience of mental health care and support. So next slide. To do this we've grown our team over the past decade to 46 researchers and professionals and we're about to double in size, this point in time. But the idea here is that we've got over 15 different disciplines working in our team. We've got professional writers, working with young people, and comic developers, experts in Computer Interaction, computer human computer interaction, and we divide this team across: Creative, they develop the content of interventions, computational, or the technology, technological elements. Clinical, this will be the clinical moderators, vocational workers and young people as well. And the research team that evaluates the impact of our interventions. Next slide, please.

And of course, as Ian was mentioning this as well, young people are at the core of our way of working we've done over 400 - 500 consultations. I think it is at the moment with young people and we have between five and 10 young people in bedded into our team, including in the payroll. And they not only help us co design and co develop the interventions, but also deliver the interventions for young people. So this is like I'm following this model. This is what most was a em was mentioning, we've created the most model, which stands for moderate on social therapy. And essentially what it does it integrates peer to peer on social networking, with expert support provided by conditions as well as vocational work is peer support provided by young people with experience together with evidence based psychological models delivered in attractive ways. Now we'd sort of adapt to the needs of each specific population. So this is a constantly evolving system, I would say. And we just released a fourth version of it in in December 2019. So next slide. And is just to show all the research, sorry, this the previous month, all the research that has gone into Most was done aid completed pilot studies and seven ongoing at the moment, we finished two randomized control trials across 44 Australian and International Youth Mental Health Services. And this is important, we adapted it to address the severity and diagnostic diagnostic spectrum at all stages of treatment as well for both young people and their families. So next slide. And this is the fourth version of most, which essentially, the value proposition is that we provide guided journeys for young people this is journeys, guided and supported by conditions but also by automatic wise coping strategies, which is in the moment support for young people when and where they need is, together with online social networking designed to build supportive and meaningful connections among young people as well. We put a lot of emphasis on fostering the therapeutic alliance and giving people personalized experiences as well. So next slide. This is some of the evidence and I'll be happy to provide all the reference for this. So we've tested the most powerful across multiple studies, as I mentioned before with 1700 young people and families. And what we can see is a high degree of safety and accessibility with the majority of young people recommending to others find it helpful, but also experiences experiencing more such a very positive, I suppose, therapeutic experience, but we also have evidence that reduces hospital admissions, misses to emergency services and improves vocational outcomes in young people in psychosis. I'm very promising I can outcome seeing other clinical and social variables that are important for us as well. So next one is the final slide. And now we are getting ready to launch most across Victoria with funding from the Victorian Government together with Telstra Foundation, and this is specifically designed to enhance

Youth Mental Health Services at all levels, from the point of access into the services provided instant access to evidence based support by path Seeing and removing effectively wireless through to receive in blended continuous and synergistic face to face and digital care that focuses on both symptomatic and functional recovery through to providing continuous access to online support to maintain their, as I said, the clinical gains of face to face interventions. So I think that's the last slide. So thank you for your attention. And as I said before, I'd be very happy to provide links to most just to show what it looks like, as well as references for the abuses that I just mentioned.

Ian Hickie

So thank you very much, Mario. I think that last point, just to reinforce the point we were making last week - why get on a waiting list? People going online already access support immediately, and some may not require more than that, and may not even need to come into services, as well as accessing the expert additional and a whole range of services that may be available. And great news, in fact I hope people outside of Victoria are listening, that actually now Victoria has recently made the decision as part of its response to recognition of many of the challenges that are faced in mental health systems to support the deployment of most across its youth services. And that's the sort of thing which of course is possible in this world is to have a large enhancement like this one that is very evidence-based, be deployed at scale, very quickly. Something that we've been arguing about in modelling in the last week to expand the capacity of the Australian mental healthcare system rapidly, can be done with digital services that is not easily done with clinics and face-to-face services in the current challenges.

So our third speaker now is Dr. Sally hunt, who actually has done a great job today of being both Marie Teeson, Francis **Cayman**(?) and herself all in one go to represent the work of the Matilda Centre as partnerships with the University of Sydney and the University of Newcastle, in areas of developing systems for young people, specifically through the eCLiPSE programs.

Sally Hunt

Thanks Ian. If I could have the first slide, thank you. It is one of my life's ambitions to try and emulate Francis and Marie because they're both such awesome humans, and to take a large amount of the credit for the eCLiPSE program as well that I'm going to talk to you about tonight. Look, before we jump into eCLiPSE, I want to talk a little bit about the frustrations that I have experienced as a clinician, that many of you no doubt have experienced, that service users have experienced, that funders have experienced, that led us to want to develop a platform like eCLiPSE . eCLiPSE is a portal, or an online platform, whereby people can access evidence-based interventions for mental health and substance use problems. The sorts of things that we were reacting to was that knowledge that there was an underutilized evidence base, having come into research from a clinical world, I was really frustrated to know that these awesome online interventions and digital mental health solutions were sitting, developed, tested, trialled in randomized controlled trials and then sitting on a shelf getting dusty, because we weren't able to get them out on a large scale to the people who would benefit from them to the people that they were that were developed for. So, Eclipse was our attempt to open that door and to connect the many, many, developed trials and programs with the people who need to use them. We were also responding to siloed mental health service, and substance use services, whereby people were triaged into one or the other of those services and often found it difficult to get support for both problems when they co-occurred. And similarly for children and young people who might be straddling that developmental boundary between child services and adult services and we felt that a program like eCLiPSE had the capacity to bridge that gap. We're also all, (and I know I'm preaching to the choir), all very well aware of the structural barriers to accessing traditional services. Young people aren't always willing and they're not always able to access traditional services for a variety of reasons, so it's incumbent upon us to meet these young people where they are, and we know that

they're online. We know that we can access them through social media, through apps like Instagram, Facebook, and Snapchat. They're not always knocking on our door to bricks and mortar service, and so we need to have a variety of pathways to care, so that we can make sure that people get the care that they need when they need it.

Also, we're aware that they're rapidly changing end-user preferences. So even in the time that we've carried out some of the trials that have led to the programs that are on eCLiPSE, we've noticed a change in preferences from having telephone contact, to email contact, now to text message contact, and we need to be able to be responsive to that and I think that digital mental health gives us the setting to really be responsive and agile in our contact with young people. We also know that there is a significant problem with stigma, and whilst great headway has been made in the last 10 to 15 years in addressing that issue in Australia and around the world, young people who might actually benefit from, and Ian just made this point, who might actually benefit from accessing services early and receiving some preventative care, certainly wouldn't identify with needing to attend a service. And so making those resources available for people who are at a subclinical threshold, if you like, is one way that we can support young people before they ever need to access traditional services. And also, of course, there's limited services available to us.

Certainly for people in rural and remote settings, there's that issue of waitlists. Services with selective eligibility criteria, and the biggie - services aren't available 24/7 or most of them aren't, so online, digital health provides an opportunity for young people to access some sort of care when they're ready to access it and when they need to access it. And the young people that we spoke to when we were developing a clip certainly told us that they experienced huge frustration when they had identified a problem that they wanted to start to work on, particularly one around substance use. That typically didn't happen between nine and five, Monday to Friday, that typically happens on the weekends, or when there's been some sort of crisis in their life. And so at that time, they want support then and there, they don't want to go on a waitlist, they don't want to speak to an intake worker and then tell the story again to somebody else. And so with a program like eCLiPSE, (and if you can move now to the next slide), what eCLiPSE allows us to do is to provide a range of services of varying intensity to both young people and older Australians, that they can access, they can do self-assessment, which allows them to get a sense of whether or not the experiences they're having, or where they sit on some sort of spectrum and understand whether or not this is something that they perhaps might want to access a more intensive service for. They're also through the process of logging into eCLiPSE able to repeat their assessment and track their symptoms over time. This allows them to to get a little notification about whether or not they might need to seek support, talk to a GP, or talk to a face-to-face counsellor.

So by no means is eCLiPSE designed to replace those services but rather to complement them. And also the results of the assessment trigger a response which suggests which of the eCLiPSE programs the young person might best access. And so, those programs, the four that I mentioned there, Shade and Deal which are both for people with depression and a range of substance use problems. Crystal Clear which speaks to methamphetamine use, and Healthy Lifestyles program which addresses cardiovascular disease risk. So things like symmetry, sedentary behaviour, smoking cessation, sleep, diet, and exercise. So the young person is then directed to the program or programs that are indicated based on their assessment results, and they can access it there. And then, so if at 11 o'clock on Saturday night, they've felt that they might need or want some support, hopefully, by midnight, they're accessing it. So as I said, it's an Agile Platform. eCLiPSE allows us to provide up to the minute advice and new information and evidence. I checked on it today is that there is now a page on COVID-19, which we were able to update really quickly so that people who are linked in with eCLiPSE can immediately go back to that site to get some more up to date support for the current crisis that they're experiencing. eCLiPSE also allows us an opportunity to provide support to clinicians. So we are able to guide clinicians to use eCLiPSE in conjunction with their treatment as usual, or as in a stepped care model for those who are

not yet requiring face to face service, or perhaps have just stepped down from a more intense level of care.

We've had great feedback from focus groups who we've consulted about eCLiPSE where they've told us that absolutely, (and we've already heard from Mario as well about the evidence) that young people certainly are already using these sorts of sites and resources. So it's our responsibility to direct them to the ones that we know are safe, to know that they are evidence-based and that they are effective, and that they will be monitored by researchers and by clinicians who are not going to put these things out into the internet and leave them there. So I think one of the key things about eCLiPSE is that we're able to respond, we're able to update, and now use eCLiPSE as a platform for new interventions as they come out. So hopefully, they won't sit on the shelf getting dusty. And once the evidence base has been demonstrated, we'll be able to roll those treatments and interventions out far more quickly than we used to. And that's eCLiPSE in a nutshell. If you move to the next page, I've just got a few references, and the link to eCLiPSE if you'd like to go and have a look at eCLiPSE, you can enter your email address and you'll receive some correspondence. If you mentioned that you've heard about eCLiPSE on this webinar, we'll be able to set you up so that you can have a test accountant and have a look around.

Ian Hickie

Sally you made some really important points about actually dealing with very specific drug and alcohol issues and of course with the work of the Matilda Centre and with Francis' work at the University of Newcastle as well, this issue of connecting with populations that classically do not get care or do not access it, particularly young people with alcohol and other drug problems. And since I was nice about the Victorian Government, I should be nice about the New South Wales Government, you know, which has particularly picked up and I think finally recognised that digital interventions is one of the ways to reach those populations we just do not ever reach and provide actually evidence-based interventions for them and their families in real time. One could well imagine during this COVID-19 period, that issues related to substance misuse may have become apparent at home. So do you just want to comment on that particular aspect, because I think eCLiPSE and the Matilda Centre and University in Newcastle have fairly unique experiences and have really driven, for those who don't know, the New South Wales Government to think quite differently about how services really do need to provide particularly young people struggling with diseases.

Sally Hunt

Well, look, I should have said it from the outset that eCLiPSE was funded by the New South Wales Ministry of Health. And so it was born out of their recognition of that exact problem. We know that even when people with co-occurring mental health and substance use problems seek help for their mental health problem, there is a delay of something like seven or eight years before they receive any support for their substance use problem. And that's for the very small percentage to actually get support at all. So eCLiPSE is about reaching the people who otherwise are not being reached. When we were developing it we had extensive discussions within health and with service providers about that very issue that if we just kept eCLiPSE, (and there was an urge to keep eCLiPSE just for people who are already engaged with services as an additional tool), and yet, we were all very clear that if we withheld something like this from people who weren't already engaged with services because of fear of risk of harm, in fact, we'd be doing them a great disservice because we know that it works in over 1000 people that we've put through trials of the various tools that are on eCLiPSE, we've had no adverse events. We know that it's a safe as the majority of things that people can access of support services that people can access online. And so we need to make it available so that we're reaching the people that need it most not the people who are already receiving treatment,

Ian Hickie

Which is a marvellous segue to our next speaker, Jason Grimes. Now people will know from previous seminars, if you've been with us over several seminars that we have had Jason Trethowen the CEO of headspace, of course the National Youth Services framework in Australia has been supported to reach communities. I was saying the Jason the other day as an original director of headspace, he was set up with the intention of asking people, it's a bit old headspace now, a bit pre the technologies we're talking about, to connect with communities in particular ways that it was not just about getting young people into clinics. It should be very placed-based and actually reach populations that were more disadvantaged. Just in case anyone doesn't know, headspace was set up to go where private MBAs, psychologists and others would fear to trade. It was meant to go where there weren't services, and connect with communities that were really struggling. And so on the ground, Jason, who's from the Clarence Valley and from the headspace service in Grafton, he's one of those people who lives and breathes that. And now in this age, where there's the danger of getting more disconnected because of the COVID-19 situations, and the discussion about whether these sort of telecommunications and digital systems are only for the wealthy, or only for those who've got really good telecommunication access, I thought it would be great to hear from somebody who is in a community in great need, who is really trying to see whether technology is part of the solution about staying connected to the communities and young people in Australia who face some of the most significant challenges. So Jason, what do you reckon?

Jason Grimes

Well, thank you Ian. First I want to back up because you segued that really well. I want to tell a bit of a story about how we came to be, so maybe the audience can have a bit of an understanding. In 2017, we were launched officially in December, we came off the back of what was three years of some of the highest suicide rates per capita in the country. I don't have the exact figure off my head, but quite a few young people were lost, and the community as a whole have banded together and formed a group called Our Healthy Clarence, which consisted of several services, community members and some of the parents who had lost their young people, and advocated very strongly for Youth Mental Health Services to be brought to the region. So from that headspace was brought into the region. And with that came this massive expectation that we would be the panacea for all the issues. So the first job that myself and my team have was to manage expectations of the community. I'm talking on the next slide, please.

So just a quick snapshot, again, to give a better idea of what we're facing. The Clarence Valley itself consists of four main communities and about 10,500 square kilometres. So when you get told to come into an area and solve problems around mental health, and it's Grafton focused, that's convenient, except for the fact that there's 10,500 square kilometres worth of young people spread out. The Clarence Valley also is home to three of the First Nations peoples, the Gumbaynggirr, Yaegl, and Bundjalung Peoples, all completely separate cultures who have different backgrounds, different belief systems, and the like. There's a population of around 55,000 people as of the 2016 census. Approximate 6.3% of that population is Aboriginal Torres Strait Islander. However, that is highly contested by the local lands councils and the people, it's actually believed to be in the high teens to low 20s, and our age demographic at headspace between 12 and 25 year olds sits at around 15.5 percent. On top of all of those factors, the Clarence Valley is known for having a very low socio-economic factors, high rates of unemployment and low education figures. Next slide.

So when we came to be, to back up to the first slide, the expectation from the community, or communities, I should say, was that the service would have to integrate and become part of the community and understand the diversity that is the Clarence Valley. To give an example of the differences for anybody who hasn't travelled this region, where I sit right now is Grafton and it sits on a river, however, also within the Clarence Valley are some of the beach-side communities which focus

on more beachside issues, there are rural and remote farming areas based on cattle production. So within this region, the diversity is so wide ranging it would be difficult to bring a service and just to fit one model. What we did was upon establishment was we targeted all of the existing groups. We had several youth focused advocacy groups, a lot of services, but no services that were adapted to actually addressing the needs of the young people. A majority of our young people who sought mental services were traveling to Coffs Harbour, or Lismore, which is approximately an hour and that's the young people had access to transportation. So what we figured out right from the start was we had to actually bring our services to these regions and these communities. So we launched a platform of events, programs and activities for brief intervention and soft introduction, which has been spoken about throughout the seminar. What that actually looked like in quantifiable data, was that for the first three years in service so far we've reached between 10 and 15% of the entire populace. That ranges from those in our target demographic of 12 to 25, to parents, to carers, to teachers, to coaches, to basically anyone we could reach that would listen to us we reached out to. We also have a unique set-up in our centre here, from what I'm told on a national level, is we have partnerships with outside of our consortium, about 12 to 15 different services. So on any given work week, Monday to Friday, outside of headspace services, but within the centre, we have between 7 and 13 service providers in the centre to cover the four core streams of headspace, but also to cover those outlying areas that might be specific to this region. So drought recovery, driving skills, again, it's at a needs basis. We find ourselves being very responsive to the community's needs versus trying to make them adapt to our model.

We also have consultation groups with the three local nations and we have representation through brief interventions. Again, I'll reiterate the last line on the slide, through basically everywhere where there's a footprint where young people might interact. So whether that's schools or sporting clubs, businesses, action groups, art groups, the gallery, everywhere we can reach. If I can go to the next slide, please.

So this slide is a bit of a source of pride for us. And this shows the approach we've taken. Every activity on here, or event or program, with the exception of two, are ongoing programs that are run by headspace staff in coordination with other services. Sometimes on our own or in coordination with young people. We have adapted our model to fit what each individual community and what each pocket of young people see is as important. Recently, and I'll just give a quick snapshot if I can, of the past year for headspace in the Clarence Valley. We've gone from drought, to a mass shooting in New Zealand where the shooter was from this town, to the bushfires, followed by floods, and now we're in COVID. So, to become adaptable to the situation and to the needs of the young people, and not just the young people with their families in the communities, has been a challenge but a rewarding challenge. So each of those activities, the reason I bring that up, why they're ongoing, we've tried to cover as many demographics within the four minor communities as we could, things like Waves of Wellness are based around circular discussions or yarning groups around surfers out of the coastal towns. Carrying Construction is a program that was started because we had four major projects and a bridge being built with two international construction companies, because they had no mental health plan. And they found that they were importing, so to speak, young people between the ages of 20 and 25, from Queensland, Sydney, Newcastle, and the mental health rates and drug and alcohol rates had gone through the roof. So we helped design a program that is now internationally recognised that they're actually imparting into the stadium project in Sydney.

The Baygal-Bundjalung Warriors, so the top right photo as I'm looking at it, is the first association with a mental health organization that any Koori knockout side has ever had. The Baygal-Bundjalung Warriors consists of about five NRL players. And from that program, we supported them in achieving a grant to do outreach to some of the most rural and remote Aboriginal areas ranging, not just in the Clarence Valley but, from Casino down to Coffs Harbour.

If I could go to the next slide. So whoops, that's Shelley. So, to hit on what Ian's talking about, and the importance for us as we see moving forward with digiHealth, especially with COVID or COVID aside, is we are already reaching a lot of these demographics locally. However, where we're failing is, we only really have an idea of what's inside of our bubble. I use that word 'bubble' because when we're in the clinic, those young people who do come to us and present to the actual clinicians, the psychologists, psychiatrists, GPs, what have you, we're not actually getting an ongoing picture of what's going on in each of these pockets. So, implementing something like the InnoWell project, with these events and sports programs and any program we have, and being able to capture that data and see what's actually happening in real time. So then we can tailor our service again, to fit the model. It's probably the biggest strength I see from this. I also see the potential to de-stigmatize. I can't speak for metropolitan areas, but my experience in working with my peers and in these areas, is the stigma around mental health is a lot higher than what it would be in metro areas, in particular in the Indigenous communities. So a program like this that is presented in a forum that is created through a collaborative process using Indigenous peoples and young people's for specifically for this region. Hopefully we'll have the effect to de-stigmatize that and actually look at some of these young people for the first time in maybe generations actually trying to access information about mental health and gain an understanding. The other initiative that makes this partnership really exciting is we, as a necessity created centralized locations within the schools and a couple of public access points, because we find the infrastructure here, technologically speaking, is incredibly poor. So by having these areas set aside inside of these designated areas that house a lot of youth, the application of this program, and the ability to gain that understanding of what's actually happening in that time capsule that we can actually capture it; it's very promising. I think that's about it, Ian. Sorry.

Ian Hickie:

Great Jason. So I mean, it's really important, I think, to give the background there and the work that we were publishing last week based on the last year of modelling in the Northern Rivers does arise out of the fact that the challenges there are great. The national suicide rate right across the region is about 40% higher in this area than the national average. And there are communities, of course, that are really challenged. The great work that you've been doing on the ground to connect with those communities. And I love the idea of getting outside the bubble. I thought the bubble was in Canberra. But you know, we forced the real idea that, of course, coming into clinics is such a Eurocentric kind of view of the world and the sort of individual psychology model that runs in clinics, as if this is easy for all people at all times and is the only way. I think, your work and that connection with communities where young people are, on their own terms, and then backing that up with the potential for the digital work and then to actually then track what is actually happening to maintain those relationships over time as being critical. It's really interesting since people again, often see the digital thing as being anti-engagement and anti-connection as distinct from reinforcing the kind of connections that you've made, and being able to track outside of our own little bubble, what's really going on in people's lives.

So, the next speaker, Dr. Shelley Rowe, is also from the Northern Rivers region and has been responsible, in association with Project Synergy, with the introduction of the InnoWell Platform across five headspace centres in the region. And I thought, again, we go to Shelley for the real world experience of what the hell happens, Shelley, when you try and introduce these standardized digital systems into clinical settings, particularly in rural and regional Australia? Because, I guess, the goal here is better standardized care, high quality care, and access to the kinds of care that young people, particularly living in rural and regional Australia, may never have experienced. Great in theory, Shelley, how difficult is it in practice?

Shelley Rowe:

Yeah, thanks Ian, thanks very much. And thanks so much for inviting me to be a part of this. I just wanted to start a little bit with a Sit Rep on where things are at. But I will go into talking a bit about how it is to implement digiHealth into regional services

I suppose I wanted to present a little bit of a picture for you about how things are for regional youth. I have presented some stats, they're not exhaustive. And there are many other stats that I could draw upon, but unfortunately all paint a fairly similar picture. We know that for youth in regional areas, they face higher rates of deaths attributed to suicide, there are higher rates of alcohol and other substance misuse. And we have a lower rate of mental health professionals per head of population. And like I said, this isn't new. And they are quite alarming sort of figures. And unfortunately, they're not really changing that much. So given that, it's actually really beholden on those with monies and those who are designing mental health care to do something differently. And from my perspective, and from those who I'm working with, for scale and accessibility, digiHealth has to be part of a system solution. It's not about replacing what's already there. It's about augmenting and strengthening the care that is already there in those communities. And frankly, there is quite an appetite for digiHealth. So, research conducted by ReachOut and Mission Australia noted that digiHealth is acceptable for young people in regional areas when they're looking for mental health care. And MindSpot statistics that were mentioned in a webinar earlier in this series noted really strong engagement in their digital platform actually higher than proportional of regional people engaging with their MindSpot platform.

Next slide, please. So, what we've been researching is digiHealth in regional youth services on the North Coast of New South Wales. And we looked at four services so far have implemented the platform using co design principles, and that's really important. We know The Senate Review Committee really emphasized the importance of co-design with regional, remote and rural communities when we're talking about mental health services and mental health interventions. We have nine months of data, although it doesn't cover a comprehensive nine months for all of those four services because we had a staged 'go live' process. Within that we had 38 health professionals using the platform across nine different health disciplines. We had 120 young people onboard and go into the platform, of those 80% completed the full multi-dimensional initial assessment. And you can see some statistics there on the screen: 73% were female; 17% identified as Aboriginal; 12% identified as having a disability. On the completion of the initial multi-dimensional assessment, 27% were recorded as high level of suicidal thoughts and behaviours; so, over a quarter of those young people. And in this platform, that results in a notification to the service and a service response. 88% had moderate to high psychological distress. The benefit here also is that we're talking about online and the depth and the complexity of online is that the young people could also choose some online tools to initiate their care and get something happening right then and there, right when they're in the moment. And we know that eight of those were being selected there, you know, tend to be those top favourites of the young people. And that 12 clinical care options were also being worked upon with, collaboratively with their clinician in the service. Next slide, please.

So, what did we learn from implementing digiHealth into regional Youth Mental Health Services? Well, implementation is difficult. But that's actually not a very new discovery. So that wasn't that helpful for my career. But even when we followed those principles of co-design, which as I mentioned have been really strongly stressed as very important in regional areas, it's still very difficult. And there are a lot of factors that impact on regional youth mental health services just in their operational, everyday operational activities, but also on their capacity to implement digiHealth. Now in terms of some of those, some of those things, they've already been documented fairly well in implementation research. But we wanted to really look at what it meant for a regional Youth Mental Health Service. And so we developed this conceptual diagram of these elements. And some of them are challenges. Some of them

are also levers; which might be in some direction quite supportive of services, impacting. So what we have here, they're all highly interrelated, but we have those community factors that Jason just spoke about incorporating demographic and cultural factors such as the Aboriginal and Torres Strait Islander community and where you have communities from non-English speaking backgrounds, including, as we have in the area up here, a number of refugee settlements, and then also the socio-economic profile of the community. There's also issues of technology and capturing digital inclusion. So how much access to devices do people have? What is the connectivity that they have in the area? But also what is their relationship with technology; in that, in this community, is a piece of technology (a device) considered a communal device that is shared around between multiple people? Is it a thing that can be transferred to cash very easily so devices move around quite quickly because they can be sold. And what is the relationship between the device and the individuals in the community. There's also the geographic issues, the issues of distance between where people reside and where the services are; transport availability. So even if there's not a big distance, but if there's no transport available, and again, it relates to the socio economic, if you can't afford a vehicle and you can't afford the petrol, you're going to have trouble getting to some of these services because there's not a lot of public transport available. And then, as Jason also mentioned, the impact of events like natural disasters, this region has had a really profound experience over the last nine months of a drought, and then a catastrophic fire season and then floods in the area. But there's also a region that's known to be a hotspot for natural disaster and that really impacts on services capacity to deliver services, to stay open, to deliver services but also on people's capacity to get to services. Then we had the health system factors the funding agency, their leadership and their culture of innovation and technology, the local mental health sector, the skills and training and depths of local workforce.

The presence ,or what I would more more often say, the absence of a stepped care system in regional areas.

And, and just what are the other services, what's the patchwork of other services in that community. And then there's the organisation itself that runs the service or the lead agency. And its clinical governance, its proximity between the service it runs and the head office of that lead agency, the leadership that it has, the skills and capacity of the local team, the culture of innovation that they have, and what resources they have available to them. And it all presents a really complex range of considerations for when it comes to adopting technology and DigiHealth.

But I go back to my original point, that's something I'd like to finish on is that there is definitely a need and there is an appetite. So we need to work within this framework, rather than against it. And I suppose I would like to finish by posing a question back to you Ian, which is in this, I'm not even going to say post COVID-19 I think we're probably still in it a bit the COVID-19 world in which all services irrespective of their location, whether it's Bondi or Broken Hill, and all communities, irrespective of their remoteness are facing challenges of accessing and delivering services, and the likely increase in mental health care needs going forward. Can these regional learnings actually be applied beyond regional areas?

Ian Hickie:

I'd love to answer your question. I was going to immediately hand it over to Liz Scott to answer but if Professor McGorry was here, I don't know why you go on about rural and regional Australia and just go Western Sydney/ Southwestern Sydney/ Western Melbourne, and the lack of access and the preoccupation of the clinic and the non-connection with the community is alive and well wherever we are and the under representation of young people in care early in the course in complex cases is true. One of the things I love about the Northern Rivers, there is a willingness to solve problems, not to say just what the problem is. But the sharing of technology as you've done, Shelley, is really encouraging

connectedness, working out how to problem solve in particular ways, the issues that Jason was just raising about how to connect with communities, so that actually, it's not just about a clinic in a place to solve a problem, but it has to connect in real life. And I think that is the learning fundamentally, you know, willingness to work with that and work with communities. I love the fact I think Jason 17% indigenous, that's a pretty good score coming through those systems. On the on the boy girl stuff not so happy. three girls, for everyone one boy, in particular thing, I must say, from my own experience in Campbelltown, I'll have Liz Scott here shortly, we had to work much better with community organisations that fetched boys into services, otherwise, we didn't get boys into services. So I think a lot is said in the digital world about you know, more young men will use technology for services while actually, that's not necessarily the case, unless you have community partnerships in place and then with the learnings that Jason was demonstrating the efforts, they're going to particularly engage young men in trouble in the Clarence Valley and elsewhere into these systems.

So I think much of the problem solving that goes on in rural and regional Australia we could learn from, and a little less winching in some of the urban places about how tough it is.

Just finally this evening, and I know we've gone over time yet again, and I blame myself for poor time keeping for that. But just finally with my partner here, Dr. Liz Scott, she's in the middle of this flip the clinic business of trying to service things. So Liz, how successful have you been so far with both Uspace (an inpatient service system), and with the outpatient special services you have, of trying to get out of telehealth into actually digital health into bringing young people into a wider experience of the kind of programs that we've been talking about?

Liz Scott:

So I wish I could say that we've made more progress given the opportunity that we had, and I have to say it's great to see some of these initiatives that are going on and to that, really demonstrate kind of innovation and quality, and the capacity to provide kind of better access to care. I would have to say our demand for our services is increased, obviously, this is anecdotal, I don't know the data across the whole service. But for our youth service we've had increased numbers of referrals. We've got high levels of people on our wait list, which we have not yet managed to eradicate. And these referrals are not just from PEC units, they are coming from the community and they are for young people who are not just worried about COVID, that they have very complex mental health problems made worse by lack of structure, lack of social contact, and by really not being able to access care during this period of time.

So clearly, we have a huge opportunity to improve the services that we run to improve our capacity, and we are not going to improve it/ I'm not going to improve it by sitting in my clinic every day and doing what I currently do. And the thing that worries me the most is that once this crisis is over, we will go back to doing what we have been doing. That we will go back to the complacency of saying, well, this is as good as it gets. And we will lose the impetus to incorporate some of these great strategies through the Matilda unit/ through Orygen/ through Project Synergy through into well into our current practice. So I think we have the opportunity to transform care to improve capacity particularly to rural and regional areas, to be able to provide better curated, better care use better peer-to-peer support has been indicated by some of the programs that we've discussed, work with communities that actually provide putting in place the digital systems that would enable us to actually track young people across the course of their illness, provide the interventions that they need, in a in the time that they need it without them having to wait to come back to face-to-face clinics, often when they have deteriorated or they've fallen out of care or they've given up hope, or they've had a major episode or episodes of suicide or self harm that is that has taken them into the hospital system. So that is my hope that is my

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wish that we will not that the hope will remain we will not go back into a sea of complacency. But we will actually take the opportunity to put these fantastic programs into practice.

Ian Hickie:

For those who may have just caught that sea of complacency, you may have heard HG and Roy on the ABC this week. HG describes Australia at the moment as cautious optimism in the tranquil sea of complacency. You know, in Australia, we just assume things are okay. The COVID-19 crisis resisted a fundamental crisis because the economic and social dislocation but also as Liz was just espousing a fundamental opportunity. One of the issues and I think it's been common to the work we've heard earlier from Mario from Sally from Joe and others and for Liz in her own work and that of Shelley on the coast with Jason is actually clinical leadership. If anyone thinks any government inside any bubble, whether it's the Canberra bubble, or the Sydney bubble or the Melbourne bubble, or the Brisbane bubble is actually going to do any of this, let's just be clear. They're not.

The issue is going to be whether those who are really engaged with services do draw on the experiences and the amount of R+D that's been done in Australia. A point that we've made on many occasions in these seminar Australia has been a world leader, academically, in the development of these things in Orygen, in the Brain and Mind Centre, in the Black Dog Instite, in MindSpot, in This Way Up, at The Matilda Centre, and other areas, lots and lots of really good work has been done. What we haven't done is actually incorporate those into regular clinical practice and systems to make those systems better.

I hope if there's an enduring theme from this evening, it's getting outside the bubble! It's actually that he clinic isn't the place that everyone has to rush into. And COVID-19 has finally done that in, and it gives us the opportunity to think about how we get out and connect with those communities, and the real challenge we face, how we connect with young people who are really - because of their developmental stage, their assets, their opportunities - in greatest difficulty. I think we have the intellectual resources, we have many of the tools and products. I think the issue is going to be actually one, not of what do the government's do next. But of the willingness of clinicians and services to actually engage locality, you know, conversation with Pat McGarry, and people know that I do speak to Pat about twice a day, he did remind me of that great saying out of American politics, which was from an Irishman, a Kennedy, all politics is local. In this case, all services are local. We actually need to make sure that in every community in which young Australians live, we reach out, we connect, we support and we use technology to bring a world of opportunity, but also to stay connected in empathic and engaging and real ways particularly for those who face many challenges in the current environments.

You'll see on the screen now a list of a whole range of useful resources that are available for the particular people who presented tonight particularly from work from Orygen, but the MOST program of Mario Alvario and of Jo's #ChatSAfe, also Sally's work with eCliPSE. And of the other works we've been associated with InnoWell, on the Northern Rivers, they can all be obtained online, the webinar has been recorded, and we will attempt to provide to anyone who wants the resources that go with it.

I thank you for your attendance again, and we will plan further seminars in the future addressing some particular issues, medicolegal and privacy being very topical again this week, how these systems actually can be better integrated with ongoing care as the government develops further responses. I've got to say, additionally, we are very grateful to the sponsors of this. We're actually not brought to you by your Australian government. We're not a program actually, of the current communication campaign. We have been very grateful to two private funders into particular – the Bupa Health Foundation, which is looking at the extent to which we can actually develop Circles of Care and further research

and Future Generation Global actually, they're investment bankers who want to invest in the future of young Australians. And so we will continue to convene these seminars trying to bring together the best local expertise and international perspectives to further education. If there's other questions that you have other questions that we haven't addressed, and I've been too slow to respond to, or we can direct to any of our speakers. Thank you. And I thank particularly the speakers who've contributed this evening, thanks for your time.