Using technologies safely and effectively to promote young people’s wellbeing

A Better Practice Guide for Services

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youngandwellcrc.org.au

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NSW CAAH works in partnership with NSW Health and other sectoral stakeholders to protect and promote the health and wellbeing of young people aged 12 to 24 in NSW. NSW CAAH’s work includes four key areas: developing information and resources to increase awareness of youth health issues; capacity building to increase workers’ skills and confidence in adolescent health; supporting applied research and promoting better practice in adolescent health care; and supporting advocacy and policy development to increase leadership and action for adolescent health.

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# Table of contents

Acknowledgements........................................................................................................ iii

Table of contents........................................................................................................... iv

Executive summary....................................................................................................... vi

Introduction...................................................................................................................... 1

1 Why this document is important................................................................................ 3
  1.1 How much evidence is out there?........................................................................ 3
  1.2 The service spectrum........................................................................................... 3
  1.3 The policy context................................................................................................ 4
  1.4 Overcoming implementation barriers................................................................. 5

2 Engaging young people............................................................................................. 6
  2.1 Social inclusion through technology.................................................................... 6
  2.2 Health promotion through technology.................................................................. 7
    Case study: Health promotion website - Tune In Not Out...................................... 9
    Case study: Warehouse Family Planning Service Facebook.............................. 10
    Case study: Using Twitter – Vibewire................................................................. 12
    Case study: Is there an app for monitoring your happiness?.............................. 13
    Case study: Health promotion using YouTube.................................................. 15

3 Direct communication............................................................................................... 16
  3.1 Email...................................................................................................................... 17
    Case study: Email support – Kids Helpline....................................................... 18
  3.2 SMS appointment reminders................................................................................. 19
    Case study: SMS appointment reminders......................................................... 19
  3.3 Chat......................................................................................................................... 20
    Case study: e-Counselling.................................................................................... 20
  3.4 Peer support networks.......................................................................................... 21
    Case study: Peer support forums - ReachOut.com............................................. 22

4 Therapy....................................................................................................................... 24
  4.1 Evidence–based health education and online counselling.................................. 24
    Resources.............................................................................................................. 25
    Case study: Online counselling - Kids Helpline and eheadspace...................... 26
  4.2 Blogs and vlogs – posting as therapy.................................................................... 27
  4.3 Self–help CBT and online self assessments......................................................... 28
    Resources for online self–guided therapy......................................................... 28
  4.4 Conducting therapy in virtual worlds................................................................. 29
    Case study: Virtual worlds.................................................................................. 30
  4.5 Serious games....................................................................................................... 31
    Case study: Serious games – RE–MISSION......................................................... 33
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and evaluation</td>
<td>34</td>
</tr>
<tr>
<td>5.1 Hearing feedback about technology</td>
<td>34</td>
</tr>
<tr>
<td>Resources for research</td>
<td>34</td>
</tr>
<tr>
<td>Case study: Research</td>
<td>35</td>
</tr>
<tr>
<td>Case study: Youth participation</td>
<td>36</td>
</tr>
<tr>
<td>5.2 Participation in service design and evaluation</td>
<td>37</td>
</tr>
<tr>
<td>Online safety</td>
<td>38</td>
</tr>
<tr>
<td>6.1 Legislation</td>
<td>38</td>
</tr>
<tr>
<td>6.2 Policy</td>
<td>38</td>
</tr>
<tr>
<td>6.3 Help and complaint lines</td>
<td>39</td>
</tr>
<tr>
<td>6.4 Resources</td>
<td>39</td>
</tr>
<tr>
<td>Case study: Boundaries of service responsibility - Reachout.com</td>
<td>41</td>
</tr>
<tr>
<td>Duty of Care framework</td>
<td>41</td>
</tr>
<tr>
<td>Young people's views</td>
<td>44</td>
</tr>
<tr>
<td>References</td>
<td>47</td>
</tr>
<tr>
<td>Appendix 1 Twitter mental health hashtags</td>
<td>53</td>
</tr>
<tr>
<td>Appendix 2 Evaluating ICT products</td>
<td>54</td>
</tr>
<tr>
<td>Appendix 3 Social media policy</td>
<td>56</td>
</tr>
<tr>
<td>NSW Police</td>
<td>56</td>
</tr>
<tr>
<td>Appendix 4 Social media policy</td>
<td>57</td>
</tr>
<tr>
<td>NSW Department of Education and Community</td>
<td>57</td>
</tr>
</tbody>
</table>
Executive summary

Young people trying to connect with the health and support services they need may meet some big challenges. Whether they feel they can’t talk about what’s worrying them with their general practitioner, they’re worried about confidentiality, or their nearest health service is too far away, young people may not get help when they need it. The challenge for health professionals and youth organisations is to meet young people where they are with the services and information they need.

Young people are increasingly online. The most tech-savvy generation ever, young people aged 12 to 24 are increasingly comfortable communicating, forming relationships and connecting over the internet and using mobile technologies. Social networking, text messaging, and apps are an environment in which many young people feel the most relaxed and able to be themselves.

This presents an interesting opportunity for health practitioners and services alike, to engage young people in the space where they are comfortable and open to new ideas and help.

Technology is also a cost-effective way to reach large numbers of young people in innovative, efficient and engaging ways for the purpose of mental health promotion, prevention, early intervention and treatment. If we do it well, we will see a shift in the burden of disease related to poor mental health amongst young people and those young people who do experience a mental health difficulty and their families will have better access to health care and information – essential to young people’s health and wellbeing.

These guidelines have been developed to help youth health and related services use technology to meet the needs of young people in ways that are innovative, safe, relevant and engaging. Service providers, policy-makers and managers will find within the guidelines an evidence base for the safe and effective use of information communication technologies (ICT) in clinical settings. Importantly, the guidelines also provide an evidence base for dismantling the structural barriers to achieving practice change.

While there is a great deal of policy support for services to make better use of technology, using it for the delivery of clinical and other health services is a new and challenging concept for some organisations. Wary of risks to data security and privacy, many organisations have information technology policies that are restrictive and not necessarily evidence-based. The blocking of particular websites and the installation of firewalls that do not permit access to particular services (like Facebook and YouTube) can limit the options open to those who want to innovate in service delivery. These guidelines seek to help people work through concerns by providing a clear guide to safely and effectively promote young people’s wellbeing through technology.

The project involved a meta-review of Australian and international literature to identify effective models for using technology to engage young people in health service design and delivery. We focused on six research questions:

- What technology and functions exist that appeal to young people?
- How is technology already being used by young people and health providers?
- What are some examples of best practice?
- What have we already learned from current practice?
- What does the research tell us?
- What relevant guidelines and policies exist?

Young people and service providers helped shape the guidelines through a consultation workshop and a project reference group.
Introduction

While most young Australians rate their health as excellent, very good, or good (Australian Institute of Health and Welfare 2011), the health of young Australians, particularly their mental health, remains a significant public health concern. Current Australian data indicates that more than one in four young people aged 16 to 24 experience mental health difficulties, including depression, anxiety, eating disorders, personality disorders and psychosis (Slade et al. 2009).

One of the biggest challenges we face in strengthening young people’s health and wellbeing is improving access to the information and services young people need to get healthy and stay healthy. We know many young people face one or more barriers to accessing health and other services (Booth et al. 2002). These barriers include concerns about confidentiality, the attitudes and communication styles of practitioners, service environments, the availability and cost of services, and the developmental characteristics of young people.

How we address these barriers has been the subject of a series of publications by the Centre for the Advancement of Adolescent Health, titled the Access series. The Youth Health Better Practice Principles (NSW CAAH 2011) identified ways in which these barriers can be dismantled, including better promotion of services.

If we are serious about reaching young people and promoting our services to them, we need to be where they are. With the increasing availability of information and communication technology (ICT) comes the opportunity for health practitioners and services alike to engage young people in a space where they are most comfortable: online (Anker et al. 2011).

Technology can be used in a variety of ways: as a tool for organising appointments, as a clinical platform for therapeutic conversations, to promote access to specific health related information and services, or even to invite young people to participate in service delivery, design or research.

These guidelines explain the different online and electronic media young people use and offer healthcare and other service providers best practice guidance for using these technologies. Drawing on local, national and international evidence, they provide information about ICT that is accurate, straightforward and comprehensive, helping services to use ICT safely and effectively to engage young people, provide information and promote access to services.

To develop this document we considered the following:

| What technology and functions exist that appeal to young people? |
| How is technology already being used by young people and health providers? |
| What best-practice examples exist? |
| What are the learning outcomes from current practice? |
| What does the research tell us? |
| What relevant guidelines and policies exist? |

The guidelines cover social networking sites, websites, email, video, apps, short message service (SMS or text messages from a mobile phone), and serious games (that is, health-focused games). The guidelines are relevant for service providers working across the healthcare spectrum, from primary health care through to hospital environments.

In terms of health promotion alone, technology offers us a unique opportunity to engage with an often difficult to reach age group (Kangua & Rosenfield 2004). Young people are increasingly using the internet as their source of health information (Mulveen & Hepworth 2006). The Mission Australia Youth Survey has also consistently demonstrated that young people are more likely to access support on the internet than they are to seek it from teachers, school counsellors, GPs or health professionals (Mission Australia 2011).

For healthcare professionals, the ease with which people can find information about health online is rapidly changing the patient–professional dynamic (Anker, Reinhart & Feeley 2011). The more information a person has, the more empowered they are to make decisions and choices about their health and their health care (Bass et al. 2006).
Research has also found that while most professionals working with young people felt confident that they could use technology to perform basic tasks, many lacked the knowledge, skills and confidence to use technology to work directly with young people to promote mental health (Blanchard et al. 2007, Blanchard et al. 2012). Many practitioners were also concerned about managing the risks associated with using technology to engage with young people.

While many positive results can be seen from the use of self-directed e–health interventions, there is evidence that these are most effective if used as part of a stepped-care model, where the client begins with online self help which leads to interaction online with a trained professional, which in turn leads to using online tools as an adjunct to face–to–face treatment (Blanchard 2011, Blanchard et al. 2012).

We have designed the guidelines to be useful for:

- policy–makers
- service managers
- professional associations
- information technology (IT) departments
- service providers and organisations
- students training to become service providers.

---

**Did you know?**

91% of 12 to 17-year-olds indicated that the internet was a ‘highly important’ part of their life (ACMA 2008).

Over 95% of young Australians use the internet (Ewing et al. 2008), with this figure growing rapidly.

The majority of young people spend between 1–3 hours per day on the internet (Burns et al. 2010a).

Online chatting was ranked as the most favoured leisure activity by young people (ACMA 2008).
Why this document is important

Chapter 1

1.1 HOW MUCH EVIDENCE IS OUT THERE?

There is now a large and growing body of research about e-health approaches to mental health promotion, prevention, early intervention and treatment, and an increasing number of published articles about e-health interventions specifically for young people. Much of the literature focuses on mental health issues (including depression and anxiety), substance abuse and smoking cessation, although there is some coverage of sexual health, generally from a health information or health literacy perspective.

Some articles report on the evaluation of specific youth health websites or portals but there is also a broader group of articles about the ways young people search for health information on the internet and on the quality of the information they are likely to find. The research literature also includes e-health interventions or social support (online support groups) for young people with chronic illness (including juvenile arthritis, diabetes, and asthma).

Most of the evidence comes from observational or control–group studies rather than randomised controlled trials (which would be very difficult to do effectively with this kind of intervention) and most of the early research is US–based (with some British and European research as well – especially from Scandinavian countries). More recently, we are starting to see much more research coming out of Australia on health information and health promotion initiatives using the internet and research about the effectiveness of online interventions [Christensen & Petrie 2013].

1.2 THE SERVICE SPECTRUM

A framework for using technology to promote young people’s health and wellbeing

This guide looks at a range of strategies: from engaging young people in health promotion through to promoting access to services and clinical treatment approaches. The spectrum of intervention for mental health problems and mental disorders can be seen in Figure 1.

Figure 1 The Spectrum of Interventions for Mental Health (adapted from Commonwealth Department of Health and Aged Care 2000).
This guide considers the treatment spectrum as its primary structure and covers the main forms of technology that are used at each stage in the treatment spectrum. For example, social media is often used to promote health and access to services (early intervention) and SMS is often used for appointment reminders. But it is important to note that specific types of technology can be used at other stages in the treatment spectrum in different ways.

Online services have their area of focus within this spectrum of interventions. For example, ReachOut.com provides prevention and early intervention while eheadspace, Kids Helpline or Lifeline offer online clinical treatment.

Face–to–face services also exist along this spectrum of interventions and can benefit greatly by connecting with young people in the online spaces as an adjunct to their current services.

### 1.3 THE POLICY CONTEXT

Many people have a role to play in promoting young people’s wellbeing through the use of technologies:

- Policy–makers can advocate for evidence–based programs.
- Health and other providers can provide their services in different ways.
- Training providers can increase professionals’ skills.
- Managers can invest wisely in technology resources.
- Community leaders can advocate for young people’s needs.
- IT services supporting professionals who work with young people can be more open to system change.
- Young people can take an active role in their health through their online engagement.

Being connected to young people means we can communicate widely and rapidly, access young people via innovative communication pathways, promote our services to the young people who need them, and provide effective support to those who need it.

The policy context has never been more favourable for health services thinking about how they can use technology to work more effectively with young people.

The Australian Government recognises that, in order to meet people’s expectations for better services, we need to transform our services: "ICT will increase public sector productivity by enabling the delivery of world-leading government services for Australian people, communities and businesses, supporting open engagement to better inform decisions, and improving the operations of government" (Australian Government 2011, p. 4).

The NSW Government has also recognised that it can improve service delivery by offering people a range of ways to connect with and access government services through one–stop–shops, apps and other technologies.

This recognition is echoed in the NSW Youth Health Policy 2011–2016: Healthy bodies, healthy minds, vibrant futures (NSW Department of Health 2010, p. 9), which identifies the importance of embracing technology to work more effectively with young people. In particular, it points out that technology offers opportunities to engage young people in discussions about their health and about how they can keep themselves safe and healthy. The policy also recognises that a growing emphasis on technology will require the workforce to develop its capability in using technology to reach out to young people through services including online counselling and advisory services, peer support groups, appointment reminders and follow–ups.

The Australian Youth Affairs Coalition, the peak body for Australian young people, has developed a policy platform that includes a statement on technology and cybersafety (AYAC 2012). Like many other bodies, it recommends that governments, corporations and communities make the best possible use of the technologies that are available.
1.4 OVERCOMING IMPLEMENTATION BARRIERS

Underpinning these guidelines are three principles designed to address the factors that prevent health and youth services from using technology to its maximum potential in promoting young people’s health and wellbeing.

Good technology infrastructure is essential for delivering and maintaining services to young people.

This means service providers need:

- up-to-date computers
- fast and stable broadband
- smartphones, tablets and other ICT devices
- access to the websites that can be used for service provision, administration and research.

Professional development for staff must include training in the use of ICT software and hardware.

Training should include keeping staff up-to-date with social networking changes, multimedia, communication management software, mobile devices and network changes, including firewall and virus protection changes at the organisational level. Service providers also need to be familiar with the use of clinical e–tools and know how effective they are from a young person’s perspective.

Policies and information management approaches should support the use of technology rather than curtail it.

Organisation policies on ICT use often mean that workers in the youth services sector are disconnected from the online world where young people spend so much time. The restriction of sites and services to workers reduces their ability to promote services and information. It also limits young people’s opportunity to provide feedback, input or ideas using technology. The ability for service providers to improve their service offerings through innovation are limited while these policies remain.

The use of technology to engage young people makes good sense because:

- It is a cost-effective way to reach large numbers of young people

There is good evidence supporting this work and a growing number of practice examples

Young people tell us that technologies play an important role in their lives

Technology enables connection and enables better ways of building partnerships and sharing information, helping to overcome a current challenge for organisations

We need to use technology to be innovative, efficient and effective in our work

Many other services use websites and social networking for service promotion
Engaging young people

Chapter 2

Technology can help services promote access to information and services and is a useful platform for health promotion and health education for young people.

Young people can find it difficult to access face-to-face healthcare services for any one (or more) of several reasons: confidentiality concerns, feelings of shame or embarrassment about discussing personal or sensitive issues, geographic distance from health care services, accessibility (young people may not have transport to get to the service) and the costs involved in visiting a health professional (Booth et al. 2002) can all stand in the way of a young person getting help when they need it.

It’s easy, then, to see why young people tend to research health-related information and look for support on the internet, which is free, anonymous, easily accessible and available 24 hours a day, seven days a week.

This is supported by Mission Australia’s (2011) finding that more than one in five Australian young people aged 11 to 24 ranked the internet highly as a source of advice and support for concerns about sexuality, discrimination, body image, depression, and self-harm. There is also growing evidence that ICT can play a significant role in clinical settings and in health promotion, particularly among young people (Chivers 2011). Clinical health services can use the internet for health promotion activities, use text messages to send appointment reminders and provide information to young people about how to keep themselves safe and healthy.

2.1 SOCIAL INCLUSION THROUGH TECHNOLOGY

Social and community participation are extremely important for healthy social and mental wellbeing. Being part of something (a community – whether physically or online) gives people a sense of belonging and connection. When belonging and connection are missing, young people can experience a decreased sense of wellbeing and emotional stability.

Social inclusion is particularly important for young people negotiating the psychosocial challenges of adolescence. It’s a time when they are trying to develop a realistic, stable and positive sense of self and grow towards maturity and independence. In adolescence, young people also work towards achieving independence from their parents and other adults; understanding their sexual identity; negotiating peer and intimate relationships; developing their body image; forming their own moral/value system; and building the skills they need for future economic independence (Chown et al. 2008).

Without social support and the opportunity to ‘try out’ their new selves, young people may it difficult to build the skills, confidence and resilience they need to move successfully into adulthood.

Social networking sites like Facebook offer opportunities for young people to connect with others. A social networking site is a website on which you can create a profile (your own page) and post information about yourself. You can also access the profiles of other users with whom you share a connection (e.g. friends, followers) and they can access yours (Henderson et al. 2011).

Young people form relationships on these sites that can complement (or in some cases substitute for) their face-to-face relationships. For young people whose circumstances or difficulties increase their sense of isolation, this sense of social belonging and social connectedness can be vital.
Evidence

As young people grow and develop, resilience (which is supported by their connection to others) is an important factor in health and wellbeing. “Resilience is not only an individual’s capacity to overcome adversity, but the capacity of the individual’s environment to provide access to health–enhancing resources in culturally relevant ways” (Ungar et al. 2007, p. 288).

Effective communication relies on the “collaborative construction of a shared contextual frame” (Werry 1996). Freed from geographic and temporal constraints, young people using the internet are forming new communities, allowing them to choose their social relationships and community memberships. The internet allows young people to connect with others who may be distant geographically and build a sense of community that doesn’t depend on transport, money or geographic location. It’s equally relevant for young people who use the internet for general communication, connectedness and engagement with social and community life as it is for young people with specific needs – such as those wanting to talk to others with a particular health condition, life situation or interest.

Fortunately for most young people, access to technology is usually good, with computers available at school or libraries and other ICT (such as mobile phones) relatively inexpensive.

A number of factors may prevent young people from accessing technology, including not being able to afford a computer or mobile phone, limited resources at school or a lack of mobile telephone reception or internet connection in the area where they live. For a small proportion of young people, particularly those in lower socioeconomic, rural or remote areas, access to technology can be difficult (Chia 2002), although more recent data challenges this notion (Blanchard et al. 2007). There is some evidence that many homeless young people do in fact have a mobile phone (although they may have little or no active credit which limits its usefulness) (Blanchard et al. 2007).

When we consider that this population group may be one of the groups most in need of healthcare information, services and support, we may need to find creative solutions to provide access to technology for young people in these groups.

But with the implementation on the National Broadband Network and the proliferation of smart phones, it seems reasonable to assume that many more young people will be able to access technology within the next five years.

Putting it into practice

| When planning technology–based interventions, make sure you think about whether the young people you are trying to reach have access to the technology they’ll need. Your approach needs to match the level of access they have available. |
| Are there ways you can improve access to technology for those who need it? |
| Think about offering young people free computer and internet access at your service. |
| Place computers in a public space so they can be monitored for appropriate use. |
| Support young people to effectively use technology–based or online services and make sure they are able to access and understand the system. |

2.2 HEALTH PROMOTION THROUGH TECHNOLOGY

The Ottawa Charter defines health promotion as “the process of enabling people to increase control over, and to improve, their health” (WHO, 1986). Effective health promotion is particularly important for young people who may engage in high–risk behaviours with potentially serious health outcomes.

Evidence

Technology gives us unparalleled access to large numbers of young people and an excellent opportunity to tailor health promotion messages to the audience. Health services could, for example, deliver information about stress and anxiety around exam time, or tips about alcohol, drugs and safe sex around the time when post–school celebrations are beginning. The provision of reliable information about health issues and health services can also prompt other help–seeking behaviours in young people (Burns et al. 2007).

Research has found that health consumers who seek information on the internet tend to search for specific conditions, search for information before an appointment with a medical practitioner so that they are prepared and search for information after an appointment to confirm the information they’ve been given or get more detail. This demonstrates a dramatic shift in the patient/doctor dynamic. The individual is now an “active consumer of health information” rather than a “passive patient” (McMullan 2006).
In a clinical setting, providing quality health information using technology can empower young people, improve their knowledge, build their confidence to ask questions of healthcare providers, and encourage them to make valuable self-care and lifestyle changes.

Young people increasingly get their information about health topics, services and support from websites, Facebook and Twitter. While they may be technologically savvy, studies show that they are not necessarily thorough in their searches (often reviewing only the first five or so results generated), nor do they think critically about the information they find (Cline & Kayes 2001; Hansen et al. 2003).

Young people’s literacy levels can also be an impediment to their search for information about health. Generally, young people use single word searches on search engines to generate information sources (Hansen et al. 2003). Poor spelling in searches can generate results for websites that also use the same misspelt words or medical terms – which tends to indicate the material may be less than authoritative (Hansen et al. 2003). Fortunately, many services circumvent these issues by purchasing google search terms that bring their websites to the top of search lists, reducing the need for correct spelling and comprehensive searching. ReachOut.com purchases hundreds of Google AdWords, meaning if someone were to type into Google.com.au ‘cant cope’ or ‘can’t cope’ ReachOut.com will come up in the top few search results.

Websites such as ReachOut.com, Kids Helpline and headspace are good examples of sites engaging in technology-based health promotion in a way that will appeal to, and be easily understood by, young people. The Kids Helpline website, for example, provides a variety of resources for young people including information about its services, a community-based service directory, health information fact sheets and a discussion forum.

Of course, everybody has different needs. It’s not enough to talk about our audience as ‘young people’: we also need to think about the differences between young people in terms of gender, race/ethnicity, sexuality, disability status, and so on.

Section three will outline and detail specific issues related to direct communication practices and problems with young people. It should be noted, that with digital mass communication technologies, such as websites, the need for constant evidence-based testing, and user interface improvement is needed for the technology to remain engaging and effective in a rapidly changing technology-driven world.

Websites

Having a website is now a basic requirement for organisations that want to promote their services and provide information to young people. A website can be a simple site providing contact details or it can be a comprehensive portal providing access to a range of information, powerful applications, and interactive services. Most organisations have a web presence somewhere between the two ends of the spectrum.

One of the biggest benefits of a website is that it can be used to provide tailored information to a particular audience while overcoming some of the most basic of barriers to traditional pathways of information access such as time constraints and service hours. Websites for young people often feature sections for fact sheets and frequently asked questions.

Fact sheets are generally short (1–2 page) summaries of the most relevant information about health, social and emotional issues. Fact sheet topics for young people might include mental illness (with subset fact sheets on depression, anxiety etc.), relationship and sexuality issues, and alcohol and drugs. Fact sheets often provide links or information to other more specific websites, or phone numbers for specific services.

Frequently Asked Questions (FAQ) pages also provide specific information about a variety of topics, but they present the information in a question and answer form. They generally deal with the questions a doctor or health professional hears regularly. Providing an FAQ page on youth-related websites can be particularly good as FAQs can help normalise experiences for young people, decrease feelings of isolation and possibly increase the likelihood of a young person then accessing face-to-face assistance. They can also be a useful resource to help a young person get ready for an appointment (what to bring, what the service will cost and so on).

Research has identified some of the important factors to consider when designing or reviewing your website to ensure it is a useful health resource for young people. Your website is your service’s presence online. If you want to engage young people through your website, consider the way you present both your organisation and the information you provide online. Some simple guidelines (Mulhern 2009):

| Be consistent in your layout and presentation. |
| Make navigation easy. |
| Use simple language. |
| Choose colours carefully, with good contrast between foreground and background colours. |
| Break large bodies of text up into manageable sections. |
Research also suggests that e-health tools (such as questionnaires or quizzes) should be interactive, easy to use, engaging, adaptable, and accessible for diverse audiences, including those for whom English is a second language (Kreps & Neuhauser 2010).

**Putting it into practice**

Things to consider when designing a website:

- Is the website easy for young people to find?
- Is it visually attractive?
- Is it easy to navigate?
- Is it accessible for young people with a disability?
- Is the information provided accurate, evidence-based and up-to-date?
- Is the information easy for young people to understand?

- How appropriate is the content for young people?
  Think about language, terminology, values and concepts.
- What age range does the website appeal to?
- Does it appeal to a range of young people including same-sex attracted young people, young people in rural and regional areas, Aboriginal and Torres Strait Islander young people, culturally and linguistically diverse young people?
- Does the website provide information about services and how to access them?
- Does the website create opportunities for youth participation?
- Does the website help young people develop personal skills and take charge of their own health?
- Does the website help health services to promote health, and to engage in prevention and early intervention?

**Case Study**

**HEALTH PROMOTION WEBSITE – TUNE IN NOT OUT**

Webby award-winning website Tune In Not Out (www.tuneinnotout.com), is a site that provides ‘24hr TV for life’s challenges’. Topics covered include alcohol, drugs, mental health, exams, sex, independence and relationships. Tune In Not Out provides both video and text-based content on these topics, and sources its information from a range of leading Australian youth agencies, such as the Butterfly Foundation, Triple J’s current affairs program ‘Hack’, and the Inspire Foundation’s ReachOut.com. The information is then collected in a ‘one-stop shop’ form for visitors of the website. This takes away the element of confusion and difficulty in sourcing accurate information, an issue that young people regularly face.

The effectiveness of Tune In Not Out lies in its strong and extensive digital media content, including videos, audio clips, images and photography. The website relies on the contribution of young people to provide this information, providing a Virtual Production Studio where young people can involve themselves in contributing to the website’s content. Young people can share their stories and participate in video production workshops.

In design terms, Tune In Not Out is youth-friendly and easy to navigate. This ensures that visitors to the site are able to easily find the information that they are looking for. Furthermore, the interactive, dynamic, ever-changing nature of the content on Tune In Not Out may increase return traffic.
The Warehouse Family Planning Service, Penrith is a youth-specific family planning agency, run by Family Planning NSW.

The Warehouse uses a Facebook page to connect with young people and reports that it (Bennet & Clune 2011):

- Makes it easy to refer young people to information about the service when undertaking service promotion.
- Gives the service a presence that is easy to access for young people who are very familiar with the media.
- Is easy to develop pages and profiles.
- Provides useful feedback about the numbers of people accessing the pages.

If you’re thinking about using Facebook, staff from The Warehouse say that, in their experience:

- Developing content is relatively easy. Maintaining interest is much more difficult!
- You need to develop policies and procedures that recognise the challenges of instant and real–time interactions in social media.
- The most effective strategies give control to the user rather than the organisation.
- If you intend to moderate interactions, comments and responses, the moderators need a level of autonomy to ensure effective and timely interactions.
- Vary your content – use pictures, status updates, links and videos.
- Embed a Facebook widget on your web pages.
- Pictures and photos of recent events will assist in giving pages an ‘image’ assisting users to identify with services.

Check out facebook.com/familyplanningnsw
A Better Practice Guide for Services

When using internet–based technologies to generate misbehaviours, such as humiliation, antagonism, full picture means interactions are far more likely to when we communicate with others. The absence of the social pressures to conform to moral standards. In the faceless context of the internet, we are also freed from body language and physical reactions.

Interactions over the internet are also very different to face–to–face communication in a consulting space. When we talk with a patient or client sitting opposite us, we are not only hearing their words, we are reading hundreds of small cues that come from intonation, facial expressions, language and physical reactions.

In the faceless context of the internet, we are also freed from social pressures to conform to moral standards when we communicate with others. The absence of the full picture means interactions are far more likely to generate misbehaviours, such as humiliation, antagonism, and misinterpretation of what is being said [Chen et al. 2008]. When using internet–based technologies to communicate, extra care must be taken to ensure the message that the client receives is the same one we thought we were sending... and that the message we hear is as close as possible to what the client was trying to say.

Putting it into practice

- Talk with young people about how they use technology, including how much time they spend in front of the screen. Does technology enhance their relationships and educational experiences in a healthy way or inhibit them?
- As a health professional keep your professional and personal identities separate on social networking sites. Do not ‘friend’ clients from your personal account. Discuss this with the young people you work with.
- Help young people to understand the privacy and reporting tools of the social networking services they use, and how to report inappropriate behaviour.
- Information posted on the internet is in the public domain; so ensure that professionalism and confidentiality are maintained (but this doesn’t mean you can’t have personality!).
- Message boards (a Facebook wall or user forums) are subject to the same laws as printed materials. Create a Facebook page that is configured so that people cannot post comments or pictures on the wall unless the content can be closely monitored.
- Be clear with young people about the extent of privacy if they use messaging functions on social network sites. While email is normally encrypted, messages can be read by someone other than the intended recipient.
- Have policies in place that support staff who interact online with young people. This is particularly important if a risk of harm is disclosed. Staff need to know how to assess risk and how the organisation requires them to respond.
- If you receive abusive or inappropriate content, issue a standard email response. Reinforce your commitment to respectful and appropriate interactions by including a friendly but very clear statement on your Facebook information page.
- The principles of good record keeping apply to all types of communication, including emails. Simple queries can be recorded on an audit form and the email and reply saved to a specific location on a secure server. Where the contact is more complex, the need to keep records must be explained to the young person, while explaining what confidentiality means for them and when information might have to be shared. This, along with data protection information can be posted on the Facebook information page.

Facebook

The impact of social networking sites in Australia and overseas, particularly for young people, has been significant. Facebook is an important social tool and activity for many young people. In a study of over 1000 students, Henderson and colleagues (2011) found that 95 percent of students in years 7 to 10 used social networking and 93 percent of those students used Facebook (and often more than one social networking site).

Concerns about the safety of young people online are very real. Certainly, social networking has brought issues like online ‘grooming’ of children and cyberbullying to the fore. However, if we manage the risks effectively, positive outcomes can flow from social networking including participation in community, educational, cultural, creative, self–expression, social development and health opportunities (Notley 2008).

In a professional context, social networking sites can let us connect with young people in a unique way. Social networking tools, like other forms of new media, allow services to access, interact and communicate within an audience that has traditionally been hard to reach. Health promotion services such as ReachOut.com use social media to engage young people in supportive communities, and to build positive messaging into young people’s social environments. Some sites engage young people in social action, facilitate participation in research, and encourage participation within their communities.

For health and youth services who want to engage with young people by building a social networking presence, there are a number of factors that must be considered. The risks associated with using social networking sites include the following legal risks (Henderson et al. 2011):

- breaking the terms of service
- copyright infringement
- privacy, confidentiality and disclosure
- defamation
- activity which constitutes criminal acts including harassment, identity theft and posting offensive material.

Interactions over the internet are also very different to face–to–face communication in a consulting space. When we talk with a patient or client sitting opposite us, we are not only hearing their words, we are reading hundreds of small cues that come from intonation, facial expressions, body language and physical reactions.

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Using technologies safely and effectively to promote young people’s wellbeing

Twitter provides real–time information in short text bursts delivered by mobile or web. Tweets are received by users who sign up to ‘follow’ a ‘tweeter’ on Twitter. Each tweet is no longer than 140 characters, and a tweeter can tweet as often as they want. You can also tweet photos and videos and retweet messages that others have posted.

Tweeting shares some characteristics with texting (SMS): it’s usually done on a mobile phone or tablet and has fixed character limits (although this is becoming less common with text messages). However, texts are usually sent to only one other person, whereas tweets can reach large networks of people interested in a specific topic.

Tweeting is considered one of the fastest broadcast strategies to alert young people to topics of interest, without using expensive advertisements. Tweeting is propelled through popularity of the consumer base: if one group of young people sign up to receive tweets from an organisation promoting good mental health, they can then retweet the message to their own twitter followers, thus creating a ‘viral’ spread of the message (Kolmes 2012).

Tweeting, however, is not conducive for treatment or synchronous (meaning ‘at the same time’) communication. It is purely asynchronous and best used by organisations for major announcements. Think of it as a loudspeaker. There are some good examples of organisations using Twitter well to engage with young people to promote health and wellbeing:

- Lifeline: twitter.com/LifelineAust
- Australian Youth Affairs Coalition: twitter.com/AYAC_
- Inspire Foundation: twitter.com/ReachOut_Aus
- Starlight Foundation: twitter.com/Starlight_star

Risk is minimised when using any social media by having a central account manager (one person, or a small group, responsible for the organisational message). It is important to establish policies that specify that tweets do not include personal messages and that tweets are not used to deliver interventions or counselling. Regularly tweet information to subscribers about where they can get help in a crisis (for example, a 24 hour counselling service or a web counselling service, if you offer those).

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Case Study

USING TWITTER – VIBEWIRE

Vibewire believes that young people should create the future, not inherit it. Young people across the world are making important contributions as world citizens, workers, entrepreneurs, consumers and agents of change. Vibewire is dedicated to encouraging an entrepreneurial spirit by unlocking the talents, imagination and creativity of youth as drivers of change, addressing important economic, environmental and social issues within our communities. Vibewire exists to make sure that young people are included (and able to participate) in conversations that matter.

Vibewire’s online presence includes a twitter page @vibewire alongside the website: vibewire.org/about

Vibewire uses Twitter in a variety of ways to achieve their mission. It’s used to promote articles written by young people on conversations that matter, inviting dialogue across networks. This enables young people to get involved and have their voices heard. Vibewire also uses Twitter as a communication channel to support young people.

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Using technologies safely and effectively to promote young people’s wellbeing
Putting it into practice

- Generally tweets should be informative and engaging. Think facts, statistics, links and quotes.
- Use #hashtags after tweets to help others find tweets (see Appendix 1 for commonly used mental health #hashtags).
- Decide on your ‘following back’ strategy. There are two main strategies: either follow a small number of people you mainly want to hear from, or follow back everyone (or almost everyone) who follows you.
- Be careful to set appropriate boundaries for young people expressing distress; refer them to a health professional rather than try to assist them directly via Twitter.

Apps

Applications for mobile computing devices such as smartphones and tablets are called ‘apps’. These small software programs have a very specific purpose – to engage users in an activity that is leisure-based, informative or both. Apps are particularly useful for regular and repeated engagement (they can be used, for example, to record weight loss and gain, monitor heart rates, record sleep cycles and so on).

Health apps are becoming increasingly popular, particularly apps for exercise management and wellbeing. While app development is prolific there are still very few mental health apps with high levels of popularity and reuse (Harrison et al. 2011).

Case Study

IS THERE AN APP FOR MONITORING YOUR HAPPINESS?

Dr John Grohol is a clinical psychologist with over 20 years of experience in researching evidence-based practice in e-mental health. In a 2012 blog post, he reviewed how apps for passive mental health monitoring (that is, monitoring that doesn’t require the user to input data) on smartphones are improving (Grohol 2012).

For passive data to be collected and recorded, the phone’s basic hardware needs to be engaged. In this study, three specific smartphone functions were used: phoning people (i.e. talkativeness as detected through the phones speaker which could detect speed of speech, pitch and tone and stress of voice); the accelerometer (which detects the phone’s movement and could communicate to an app when you go to sleep and when you pick your phone up in the morning); and the GPS, which can track the amount of exercise through distances walked or ran in a day.

While each of these functions could potentially (if somewhat crudely) measure key mood factors and allow an assessment of mood, the technology is still very error-prone and not precise in determining if someone is suffering from depression or other health problems.

On the positive side, such apps are a step forward in developing effective e–mental health apps. Given the rate of technological progress, improvements in accuracy in smartphone apps and hardware functions are likely to deliver more accurate passive mood detection in the future.
Researchers from Northwestern University, USA, are currently working on ‘Mobilyze’ – a mobile phone app for people with mood disorders. It is a complex app designed to be simple for users. The app stays in continuous connection with the user, monitoring a range of factors using sensors within the phone (including location, ambient light, social context among others). After an initial ‘training period’ in which the user provides information to the app, the app ‘learns’ to read the user’s mood and location and provide behavioural prompts or interventions much like a therapist or counsellor might (Mohr 2012). For example, if the app senses from GPS, motion data and call logs that the user has been at home for a long period with few incoming or outgoing calls and little motion detected, the app might suggest the user go for a walk or call a friend.

An app that utilises evidence–based therapy and psychoeducation is ‘iCouch CBT’. It leads the user step–by–step through the processes of cognitive behavioural therapy. The user starts by filling out the ‘what happened’ screen, describing an upsetting situation. Next, they describe their negative thoughts from the situation. From there, they add their emotions and rate their intensity. Lastly, the ‘think about it’ section asks them to describe what they’re thinking. Once they’ve described their thinking they have the chance to evaluate it and select the distortions that may be negatively influencing their feelings. iCouch CBT allows users to customize the app by adding their own emotions or thought distortions and deleting the ones that are built–in.

Once the user has evaluated the situation that is troubling them, they are prompted to enter in a thought on how they could more constructively deal with the situation if it were to reoccur. They then save the situation to ‘my log’, email it to themselves or a therapist or, if they are not seeing a psychologist or counsellor, they are able to submit it in–app to iCouch for an evaluation by a licensed psychologist. If a user does submit their situation to an iCouch therapist, they receive a personalised evaluation and suggestions specific to their situation for a small fee completed via–step through the processes of cognitive behavioural therapy. The user starts by filling out the ‘what happened’ screen, describing an upsetting situation. Next, they describe their negative thoughts from the situation. From there, they add their emotions and rate their intensity. Lastly, the ‘think about it’ section asks them to describe what they’re thinking. Once they’ve described their thinking they have the chance to evaluate it and select the distortions that may be negatively influencing their feelings. iCouch CBT allows users to customize the app by adding their own emotions or thought distortions and deleting the ones that are built–in.

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Services such as this do not currently exist in Australia. However, if organisations chose to invest in such app developments, it is estimated that engagement by young people in prevention strategies for mental health would increase, just as they have in prevention strategies for physical health through existing apps (Grohol 2010). Young and Well CRC partner Queensland University of Technology is currently developing a range of apps that aim to improve young people’s wellbeing. Further information about these apps can be found on the Young and Well CRC website youngandwellcrc.org.au.

**Putting it into practice**

| Apps should be simple to download, easy to operate and be have a clear and specific purpose. |
| Apps should provide a database for information collection either on the users mobile device or through a cloud–based server. |
| Apps, wherever possible, should be cost-effective for the user. Health-promoting apps should be free to access. |
| Apps should be registered to the organisation and copyrighted. |
| Once an app is developed, the author/organisation needs to ensure it is regularly updated for operating system upgrades across platforms, both old and new, and of differing operating systems. |
| Stick to your strengths. If you want to develop an app for health promotion, engage a technology development group to do the app building. If you’re a health provider, use your expertise to develop the strategy, impact objectives and content and allow the developers to make the app useful, attractive and engaging. |
| All apps researched, developed and released by health promotion organisations need to come with a legal disclaimer that the App is not a replacement for direct consultation with a medical or allied health professional. |

**Video**

Online videos are an increasingly popular way to communicate complex ideas or messages quickly and succinctly. YouTube allows anyone with a video camera, camera phone or webcam to create a short film for others to view and comment on. Videos can be viewed on desktop computers, laptops, tablets, smart–TV and smartphones.

YouTube is a standard plug–in for all ICT devices and is integrated with social networking sites like Facebook. The number of YouTube downloads increases daily, but it is estimated YouTube is used for searching for specific public health information almost as much as popular search engines are for general information (Keelan et al. 2007; Vance et al. 2009).

Many websites now embed YouTube clips in their content management systems (CMS) or have direct links to a YouTube channel for their organisation. This lets providers keep an archive of clips related to a particular theme or topic such as mental health or cancer.

YouTube video clips are particularly effective for engaging young people (Chau 2010). When organisations disseminate information via short, relevant and age-appropriate YouTube clips (using language and a host who appeals to young people), then reposting of the YouTube clip is
likely to occur on Facebook or via Twitter. YouTube clips can quickly become ‘viral’ spreading across networks (Lavaveshkul 2012)

Young people tend to perceive YouTube clips as more accurate, up-to-date and trustworthy than static web page posts or emails. The production of YouTube videos for psychoeducation, narrative-based accounts of personal stories, and youth engagement in promoting mental health services is likely to be a worthwhile investment. The time invested by a health organisation in producing a short video is likely to yield a greater level of engagement by young people with the service.

Putting it into practice

| YouTube clips are normally short (less than 4 minutes). They need to be downloadable at different resolutions to account for different user connection speeds. |
| Your video should tell a story with a clear message, and a beginning, middle and end, so the user remains engaged and sequentially informed. |
| Where possible, do not use scripted actors. Natural conversation or ‘ad lib’ dialog is always more engaging than staged segments (Strangelove 2010) |
| Make sure that your video reflects diversity so that young people have a better chance of seeing themselves engaged with your service |
| Use captions for the hearing impaired. |
| Use different settings, activities, individuals and groups. This is more engaging than a static presenter with a single backdrop. |
| Good editing of your clip and using music that is popular or relevant to your message can be a great way to encourage circulation of your clip amongst your audience. |
| Be careful to not infringe copyright by displaying graphics, re-broadcasts of TV, movie or soundtracks without prior permission for your YouTube clip. |
| The most engaging way to use YouTube clips is to produce a series of episodes to tell your message. Each clip tells a short story that contribute to a longer series, encouraging repeat views and returns – a bit like a television series. |
| If you decide to allow viewers to leave feedback on your YouTube clips make sure you have a moderator to review all comments for suitability. |

Case Study

HEALTH PROMOTION USING YOUTUBE

Using YouTube clips for health promotion and youth engagement is popular in Australia. Kids Helpline has run some very effective YouTube campaigns on cyberbullying, and ReachOut.com has also had success with their information clips on mental health. The secret of their success? Use animation, music, ‘real people’ as presenters and, wherever appropriate, humour!

Some examples of YouTube clips from Australian organisations include:

- headspace.org.au/is-it-just-me
- YouTube.com/beyondblueofficial
- ReachOut.com
Health practitioners sometimes find communicating with young people challenging. Meeting young people in spaces where they are comfortable can help us build rapport and improve communication.

Despite the increasing popularity of video blogs (vlogs), podcasts and other media, most online communication is still written, albeit typed. But online communication is very different from traditional written communication.

In fact, communication using technology (such as chat, online discussion forums or emails) can be more like oral communication: it’s less formal and usually features more overlap and redundancy. This informality can lead us to forget the permanency of emails and forum posts, raising privacy and confidentiality concerns down the track.

The depersonalising nature of online communication is also widely acknowledged. It is thought that the absences of our usual social cues (facial expression, gesture, pitch and intensity of speech) make us both less inhibited and de–individualised (less compliant with social conventions and norms) when communicating online than we would be if we were face–to–face (Nguyen et al. 2012).

The disinhibiting effect of online communication is thought to occur in part because of the apparent anonymity offered by online communication. This can be fantastic for asking awkward, embarrassing questions or seeking information that may lead to one being stigmatised, but it also means young people need to be careful they don’t post overly personal or detailed accounts on online message boards or mailing lists, if they don’t want these to be archived or referred back to in any context.

Young people tend to be more comfortable with the conventions of technology–based communications such as emoticons – symbols and small graphics that convey emotion and tone – and net–speak, and they may disclose sensitive or serious information in what seems to be a very informal way.

While these factors don’t lessen or increase the effectiveness of online communication, it’s worth remembering that they do seem to intensify ordinary communication processes.

Successful online communication is guided by an explicit list of ‘rules’ based on accepted ‘netiquette’ (net etiquette). You might ask posters to stick to plain English rather than net–speak (but remember this can be tricky for young people who communicate so frequently in net shorthand that it is second nature to them). Remind users that material is archived and that they should think about the sort of personal or sensitive information they post. Guidelines also help to establish what sorts of posts are appropriate, according to the capabilities of the service.
making use of the ICT. For example, message boards or portals that include information about mental health issues should make it clear they are not crisis services and direct visitors to the site to appropriate channels for seeking help.

3.1 EMAIL

While young people favour more instant forms of communication, in health services email remains the most popular, accessible and monitored form of communication technology (Car & Sheikh 2004a).

Email lets the user control the message, the flow, their contactability, time and reflection (Nguyen et al. 2012; Suler 2004; Campbell et al. 2006). It’s also popular because set up for individuals and organisations is usually free or very low cost. Emails are achievable, legally valid records of communication and reflective inquiry. Email is also globally accessible and can be shared across services with no technological barriers.

While generally unsuitable for crisis care, asynchronous forms of online communication like email can be particularly useful when time for reflection and delicate phrasing is necessary. It can also give professionals time to locate relevant resources and information before responding to individuals and groups (Barak 2007; Nguyen et al. 2012; Kraus, Stricker & Speyer 2010).

Patient–to–provider email communication allows young people to feel more able to ask questions; increase their understanding of the service and potentially reduce their number of face–to–face appointments (Car & Sheikh 2004b).

Evidence

Email consulting and counselling by health service providers (including social workers, psychologists, general practitioners, psychiatrists and occupational therapists) is probably the most well-established form of ICT service outreach around the world (Kraus et al. 2010).

We can find evidence of healthcare management using email from the early 1990s: both the United States and Israel used email to provide services to their deployed armed forces (Manthei 1995; Barak 2007). Today, there is a large body of literature about the use of email consultations amongst a range of health organisations and providers. The recurring themes of online safety for the client, legal obligations for record keeping for both client and service provider, and the proactive and empowering benefits for the wellbeing of the consumer are consistent across more than two decades of research.

Leading experts (Barak 2007; Grohol 2010; Rochlen, Zack & Speyer 2004; Nguyen et al. 2012) have researched the effectiveness of online asynchronous counselling compared to that of face–to–face counselling. Their research has found online counselling to be effective, especially when it is paired with face–to–face counselling or other online self–help activities (for example, completion of self–guided online cognitive behavioural therapy modules). Each of the researchers comes from a health background with a focus on mental health. Their primary research aim is to ultimately reduce the stigma attached to seeking help face–to–face for mental illness, and so they regard online counselling as an optimum entrance point to seeking mental health counselling.

The body of research from these experts and other experts in the field that has demonstrated the effectiveness of online counselling has led to the use of online consultation for obesity (Harvey et al. 2012), cancer (Kyngäs et al. 2008; Klemm et al. 2003) and heart disease (White & Dorman 2001). Each of these disease areas have successfully used online counselling as an intervention. Notably, the World Health Organisation is now focussing on each of these disease areas and how ICT can be used to prevent and manage the health implications of these diseases.

Research also shows that the anonymity offered by email can help young people who feel embarrassed about talking with health professionals to seek the help they need. While young people are more likely to access telephone counselling for family and relationship problems, they are more likely to disclose information about risk of harm issues when they seek help via the more anonymous email and web counselling services (Kids Helpline 2011).

Putting it into practice

When using email for counselling or to provide professional advice to young people:

| Be clear about crisis management. Make sure you have the real name, telephone number and address before you begin communicating with someone via email. |
| Be clear about expectations: negotiate timeframes for response. |
| Remember that emails are legal records of communication. They can be printed or saved into client files. |
| Set up an ‘out of office’ reply that is activated after business hours and for days off. Include information about how young people can get help in a crisis, and a timeframe for a response from you to their email. |
CASE STUDY

EMAIL SUPPORT – KIDS HELPLINE

In 2005, Kids Helpline (kidshelpline.com.au) researched the effectiveness of their email counselling service (Rawson & Maidment 2011). The findings of the study identified that counsellors and clients could develop a therapeutic alliance through asynchronous chat (email) regardless of not having verbal and non-verbal cues that are present in face-to-face therapy. The study found that the time taken to email one another helped both the client and the counsellor to reflect about the problems being discussed.

Added text tools, such as emoticons, helped the client to convey emotion or humour which also aided in the therapeutic process.

Young people reported that they preferred email because it allowed time for trust to develop between counsellor and client. Email also gave them time to reflect on their emotions when writing.

Although email is considerably slower than tele-counselling, young people reported that the time delay in responses appealed to them, as it increased rapport with their counsellor and gave them something to look forward to (counsellor email responses).

Most notably, young people reported that the passage of time in their correspondence with a counsellor allowed them to work at personal change and report back on it.
3.2 SMS APPOINTMENT REMINDERS

Short message service (SMS) is a text messaging service capability of phone, web, or mobile communication systems. It’s often referred to as ‘texting’.

Texting is thought to be the most widely used data application in the world, with over 72 percent of all mobile phone subscribers (SMS Feedback 2012) using the function. The main use for SMS by health services is for appointment reminders and health promotion messages, although it has also been used for text-based advertising of health products in the wider consumer market (Department of Health and Ageing 2007).

Early evidence strongly suggests that SMS appointment reminders are useful for improving appointment attendance for disadvantaged young people who frequently fail to attend appointments at health services (Furber et al. 2010). SMS messages can aid recall of appointments, improve continuity of care, allow appointments to be rescheduled if necessary, and are particularly useful in improving appointment attendance for young men – especially those under 18 years of age. They have also been proven effective for people from culturally and linguistically diverse backgrounds (O’Mara et al. 2010).

SMS contact with health providers can also be useful for self-monitoring and follow-up, especially in chronic illnesses such as diabetes, asthma and mental health problems. Texts can also be used for medication reminders, which may improve compliance with young people’s medication regimens (Laursen 2010). In an investigation of the effectiveness of an SMS counselling program for young cannabis users, Laursen found that the flexible, convenient and anonymous nature of SMS interaction was the key feature that led young people to appreciate this mode of intervention. They also found the use of mobile phones to access information or reminders to be culturally acceptable in ways that other health seeking behaviours would not be.

SMS can also be used for health research with young people, including SMS diaries for recording health behaviour (Lin et al. 2010), client satisfaction (Haller et al. 2009) and symptom scores (Mangunkusumo et al. 2005).

Case Study

Furber and colleagues (2010), audited the number of text (SMS) messages sent and received over a seven month period between a youth mental health outreach service centre and its clients. More than 75 percent of the text messages were about appointment scheduling. The study also looked into the inappropriate use of SMS between young people and the service centre, which resulted in only two percent of the SMS traffic being classified as inappropriate use.

The study concluded that the centre’s experience of using SMS with their clients promoted greater access to a therapist or support officer by improving engagement and retention of clients.

Putting it into practice

- Most client and business software for health services include automated SMS to clients for bookings and cancellations.
- Texts are especially useful for appointment reminders as well as for mood monitoring and medication reminders.
- Young people may be able to receive but not send messages if they are out of credit so mobile phone calls to the client as a secondary reminder may be necessary.
- Think about ways you can record the content of text messages in client files.
Unlike email communication which features a lag between message and response, online chat happens in real time (synchronous). To a degree, it feels like a regular conversation but it also involves the option to pause the conversation for reflection, to review what has been said (because the text of the conversation is recorded), and to include emoticons in the conversation.

Emoticons have been found to be as important in communication online as regular sentence and grammar use (Dekks, Bos & Grumbkow 2007). However, they can be overused, just as some punctuation is overused by young people (for example, exclamation marks!!!). Given this, counsellors may need to explore and confirm the content and intensity of chat messages to determine the seriousness of a situation that a young person is describing.

Online chat often features acronyms (known as net–speak) for fast communication of common phrases (like IYKWIM: “if you know what I mean”). This is very similar to SMS language, known as text–language. If you’re not sure what an acronym means (and the number of acronyms in use is always growing) consult a glossary of net-speak.

Evidence

Online synchronous counselling (e–counselling) has been used by health organisations and private practitioners since the early 1990s. In Australia, e–counselling is a major outreach and intervention resource for Boystown, Kids Helpline, LifeLine and Counselling Online. The effectiveness of this approach has been well–studied (Campbell et al. 2006; Barak et al. 2008, Sethi et al. 2010) and in 2012, the Australian Psychological Society released its first guide to internet–supported psychological interventions, providing recommendations for psychologists and counsellors about conducting e–counselling (Australian Psychological Society 2012).

E–counselling offers several benefits to clients. It provides access to counselling support for people who might otherwise not be able to access such support because of distance or disability; it allows a degree of anonymity, which gives people a sense of confidence about asking questions and seeking information about sensitive issues; and it allows people to connect with other people who share health issues or health conditions.

Putting it into practice

| Online chat with a young person must start with the health service provider explaining any limitations to the help the provider can give through online counselling or consultation.
| This includes having the young person agree to a safety plan which includes providing their real name, address and telephone number or the name and number of a relative they trust.
| The counsellor must be clear with the young person about confidentiality and the legal limits of the online counselling and consultation format.

Case Study

E–COUNSELLING

Traditionally, e–counselling was carried out using only asynchronous modes (email). Today, it is delivered using messenger programs or chat rooms in synchronous communication. Counselling techniques are based on narrative therapy styles (Payne 2006), involving introspection and clinical dialogue, while drawing on the typical rapport–building skills that face–to–face therapy employs.

Speyer and da Silva (2012) provide an excellent example of therapist / client dialogue which outlines the process by which e–counselling can work. It uses the CARE model, to engage the client by:

| connecting and containing
| assessing and affirming
| reorienting and reaffirming
| encouraging and empowering.
3.4 PEER SUPPORT NETWORKS

The internet is increasingly becoming a tool for young people to discuss and troubleshoot health–related problems. Online peer support networks allow young people with health–related conditions to share stories, seek advice, and work through solutions to common problems. They can be particularly useful for young people from minority groups to connect with others with similar experiences and backgrounds.

Typically, an online support group member will initiate a discussion by starting a ‘thread’ that contains a question, story, or other topic for discussion. This thread is available for other users to see, read and reply to. The discussion is usually stored within the online community’s website and can then be revisited as a reference resource or for further discussion at a later date.

Users find this form of discussion useful for several reasons. Like other forms of internet communication, anonymity leads to a level of disinhibition which helps young people raise controversial or embarrassing topics. As long as an internet connection is available, discussion can be accessed at almost any time or place. The reach of the internet typically means young people can find others to relate to where this might have been otherwise difficult or impossible (particularly important for a person with restricted mobility). Similarly, members of minority groups or those with uncommon conditions may find support online (for example, young people identifying as gay, lesbian or bisexual, or young people who have a chronic illness like cystic fibrosis).

One downside of discussion boards and online groups is that many do not have the online supervision of a health professional or trained moderator. Typically, advice or information is provided by users who have had shared experiences. Where this information is technical, its accuracy cannot be assured.

Evidence

There are many online health–related communities emerging for young people including Livewire, and the Starlight Children’s Foundation. The ever–expanding nature of the internet has led to the continued growth and creation of an increasingly diverse mix of online communities.

Available evidence suggests online peer support networks benefit young people by being specific, disinhibited, and easily accessible (Eysenbach 2004; Klemm 2003; Wright 2003). Studies have also shown that those who participate in online forums cope better with their health conditions both socially and medically (Tanis 2008).

The same studies, however, also found that social coping worsened when online groups were used to discuss the health conditions themselves (Tanis 2008). The authors suggested these online groups may run the risk of reinforcing feelings of perceived hopelessness associated with some health conditions. As many of these forums are not supervised by health professionals the propagation of misinformation in this group is a serious concern.

Putting it into practice

| Visit and view online communities that are supported by government (e.g. headspace) or non–government organisations (e.g. ReachOut.com) before you recommend them to young people. |
| Think about whether your client may benefit from online support which may have advantages in specificity for minority groups, flexibility for those who are socially isolated, and disinhibition (removing embarrassment about their issues or help–seeking or due to privacy concerns). |
| Recommend online forums where professionals or trained moderators moderate the discussion and posts on the forum, to ensure safety and appropriateness of the material. |
| Be wary of unmoderated online support groups where young people may be at risk of having negative health perceptions reinforced (particularly important for young people with eating disorders, chronic pain, food sensitivities, depression and other mental health conditions). |
| Be aware that online groups can contribute to the spread of health misinformation and myths. Find and recommend more reliable sources of web–based information. |
Using technologies safely and effectively to promote young people’s wellbeing

PEER SUPPORT FORUMS – REACHOUT.COM

The ReachOut.com online youth mental health service provides online forums where young people can discuss issues related to mental health and wellbeing – from everyday troubles to serious difficulties. They provide a safe, stigma-free space for young people to access information and to be supported by, and feel part of, a community of their peers [Webb et al. 2008].

Young people can ask questions, follow discussions and share positive self-help or formal-help experiences. The forums provide a space where young people can seek help, find out what has worked for other young people, and seek reassurance that they are not alone in their experiences.

“[The forums] are a really relevant and practical way to me to look at my problems. I love reading the feedback, tips and experiences of others because I feel less alone and integrate their tips into my own life if I think they’re useful. I also love sharing my own experiences to get advice from other people and to help others if I have any good tips.”

–Quote from forum user, ReachOut.com Online Forums Evaluation (unpublished).

Youth workers or psychologists also regularly facilitate discussions on sensitive topics. In conjunction with the ReachOut.com support staff they lead discussions and provide appropriate advice on how to deal with difficult mental health situations.
The forums are moderated by a two-tier group of support staff. Peer moderators attend six-monthly training sessions and monitor the forums throughout the day – facilitating discussion, responding to questions and referring to appropriate content and services. A group of qualified support staff provides the second tier of support – responding to serious disclosure or distress and supporting the peer moderators.

In a 2011 evaluation of the ReachOut.com service, 75 percent of respondents believed ReachOut.com increased their understanding of mental health issues, 72 percent learned more about someone else’s experience of having a mental health difficulty, and 65 percent indicated it helped them understand how to help someone else struggling with a mental health difficulty. By providing a youth-driven space to seek help, supported by professionals, ReachOut.com helps young people help themselves.
Therapy

Chapter 4

Health education websites, online self-reflection tools (blogs), evidence-based self-help programs and video games can be an engaging – and sometimes fun – way to engage a young person clinically.

This chapter provides examples and evidence-based studies on the range of online therapy modalities commonly accessed by young people.

Chapter 3 addressed specific forms of online communication used for counselling; that is, the technology that can be used. Chapter 4 will focus on the evidence-based practice of health education, online counselling, reflective therapy, self-help therapy, therapy in virtual worlds and serious games.

4.1 EVIDENCE-BASED HEALTH EDUCATION AND ONLINE COUNSELLING

In chapters 2 and 3, we looked at how email and chat technologies are becoming increasingly popular with youth health and other services wanting to engage with young people online. Because of the growing popularity of these technologies, it’s important to understand the help-seeking behaviours and constructs that are needed for these interventions to be effective. There’s also a growing body of evidence about risk management and duty of care that service providers need to be aware of.

Evidence

Neal and colleagues (2011) and Feng and Campbell (2011) explored mental health help-seeking behaviours in Australian and Canadian young people aged 18 to 25. Each study independently found that a large majority of young people first seek information about mental health and behavioural concerns using a search engine.

When using a search engine to find sites, a young person is most likely to visit and use those websites that offer psychoeducation without psychological or medical jargon. These are the sites that deliver basic help tips or a clear “flow chart” process that the young person can use to access help with an online counsellor. Websites that are written in plain language and that are simple to navigate are likely to be the most successful in encouraging young people to move from information seeking to actual treatment for a specific mental health problem.

Chapter 2 talked about how important website construction is if we want young people to not just visit the site, but to remain there, explore the resources and perhaps move from psychoeducation to an interactive form of therapy. If a website also provides 24/7 hour access to synchronous e-counselling, it is highly likely to be successful in helping young people move from information seeking to actively engage with a counsellor.

Telehealth counselling (using Skype) is growing in popularity but is more often used by medical practitioners than psychologists and counsellors (Richardson et al. 2009). Research into the effectiveness of this sort of service is very promising (Baker & Ray 2011) and the low uptake of this form of online counselling is most likely due to:

1. Young people being less willing to chat face-to-face, even over the internet.
2. A low level of broadband uptake across Australia compared to Asia, America and Europe.
3. A lack of guidelines on risk management for online counselling.
E–counselling using email or chat has been evolving since its introduction in the late 1980s and early 1990s in the United States and Europe. Given this, there are now many publications to support the safe delivery of e–counselling and the technical aspects of delivering these interventions.

**Putting it into practice**

- Make sure health education information is provided in clear language for young people. Avoid medical and mental health jargon wherever you can.
- For safety guidelines, refer to governing accredited mental health bodies and/or federal/state government online communication directives. For discussion and examples see Chapter 6. Make sure you clearly explain the limitations and boundaries of the online counselling process, both on the website and at the beginning of online counselling.
- Focus on empowering young people to move from online counselling to offline services including face–to–face counselling. It is important that young people are assessed properly in person and encouraged to engage in traditional face–to–face counselling in addition to online counselling. This treatment model is considered to be best practice for treatment of such mental health disorders as depression and anxiety (Sethi et al. 2010).

**Resources**

If you are interested in learning more about e–counselling, there are many publications that have developed or endorsed by peak organisations such as the Australian Psychological Society to help your service develop an understanding of how e–counselling works:

- Canadian Psychological Association 2011, Providing psychological services via electronic media: ethical guidelines for psychologists providing psychological services via electronic media, accessible from www.cpa.ca/aboutcpa/committees/ethics/psychserviceselectronically/
Case Study

ONLINE COUNSELLING – KIDS HELPLINE AND EHEADSPACE

Kids Helpline and eheadspace are two services providing web-based support service that offer free, confidential and anonymous counselling to young people between the ages of 12 and 25 years with, or at risk of developing, a mild to moderate mental illness. These services also provide referrals to other appropriate services, including mental health, alcohol and drug, social and vocational services.
4.2 BLOGS AND VLOGS – POSTING AS THERAPY

Some young people like to keep a reflective journal. More and more often, they are choosing to keep their journal online as a blog (short for web-log) or video, known as a vlog (usually YouTube videos or a private YouTube Channel).

Blogs and vlogs can be useful as a supportive reflection tool between appointments with health care providers. If the young person is open to it, a blog or vlog can also help them connect with others who suffer from similar problems or who simply relate to the situation of the young person. This can provide a self-promoted social support network for the young person. Although the benefits of reflecting on one’s problems through writing or video are known to supplement guided therapy (Doll & Doll 1997), the major concerns about this form of self-focused reflection online are about privacy. Studies have shown, however, that most young people over the age of 15 are very savvy when it comes to protecting their identity online (Tynes 2007; Livingstone 2003).

Bibliotherapy (reading to help a person heal from trauma, depression and stress) has remarkable benefits for those with mental health disorders. Now new research is providing evidence that writing in a public or limited-access web forum may produce benefits beyond self-help psychological therapy.

Wapner (2008) reviewed the extent of literature about blogging and found it was an excellent modality for helping people of all ages in coping with disease. She outlined that some hospitals had started hosting patient-authored blogs on their web, featuring feedback from readers including doctors and patients alike as validation of their ill-health and treatment experiences.

For mental health, blogging has the potential to remove stigma and help nurture communities of young people to support one another through chronic mental health disorders, such as depression and anxiety, as well as addiction, personality and psychotic disorders.

Putting it into practice

- Make sure that the young person who wants to blog or vlog understands how to control who views their writing or video.
- Explain that removing material from the web does not always mean it is completely or permanently removed indefinitely.
- Encourage the young person to consider using an avatar and pseudonym to represent themselves anonymously on their blog or vlog.
- Discuss the purpose of the blog or vlog and how it might supplement the young person’s journey to better health and wellbeing. It is important not to just suggest a young person to blog, but to ensure the blog is both purposeful to the young person and, if reasonable, to the shared therapeutic process between therapist and client.
4.3 SELF–HELP CBT AND ONLINE SELF ASSESSMENTS

Online assessments for depression, anxiety and stress, personality traits and IQ have been readily available on the internet for many years. In the late 1990s and early 2000s, online assessments were supplemented with early forms of self–guided therapy modules, mainly based on CBT.

Online self–guided therapy services usually ask a consumer to ‘enrol’ in a program and open a user account. This allows all their information to be kept on a secure server. The user can login or log out at any time, allowing them to work with the therapy tool at their leisure.

CBT has an excellent evidence base for helping people with low–to–moderate levels of depression to systematically work through incorrect ‘causal thoughts’ and to introduce thought processes that are rational and ultimately more healthy when dealing with the symptoms associated with depression. Both assessments and self–help CBT can be provided online by health services.

Evidence

There are a huge number of mental health assessments available online and they need to be dealt with cautiously. While young people are likely to engage in self–testing, it is important that free online tests for mental health symptoms are labelled as only providing an ‘indication’ of symptoms, not a diagnosis. A number of websites have followed best practice by providing a disclaimer that the young person should discuss the test and its meaning with a doctor or counsellor. Others provide access to evidence–based psychometric instruments and then provide directions to services that can help if the young person is worried by the results.

Online self–guided CBT modules have been pioneered by experts globally, but most notably in Australia by Professor Helen Christensen and Professor Kathy Griffiths through MoodGYM. Launched in the early 2000s, MoodGYM has been extensively tested and found to be extremely effective for young people who have low to moderate levels of depression and stress. It has been found to be even more effective when used as an adjunct to face–to–face CBT therapy (Christensen, Griffiths & Jorm 2004; Christensen et al. 2006; Sethi et al. 2010).

Online self–guided therapy programs are now progressing into behavioural areas beyond depression and stress.

Putting it into practice

| Online surveys and questionnaires, such as psychological tests, must be from reputable websites. They should be accredited or authority based endorsed by recognised mental health organisations. |
| The websites should provide scientific evidence for their tests and referral information for consumers to access mental health or counselling support. |
| Online self–guided therapy programs such as CBT should only be recommended to consumers if evidence base testing has been completed. Check for peer–reviewed publications through scholar.google.com on specific online therapy programs. Look particularly for those that have been evaluated using a Randomised Control Trial Design. |
| Inform the young person that online self–guided therapy programs are mid–to–long term therapy programs for their issues. They are not quick fixes, and it’s highly beneficial to also seek counselling or medical help to ensure issues are fully dealt with. |

Resources for online self–guided therapy

Depression self–help
moodgym.anu.edu.au/welcome
ecouch.anu.edu.au/welcome

Anxiety and panic
virtualclinic.org.au

Bipolar disorder
moodswings.net.au

Substance abuse
ontrack.org.au/web/ontrack/home

Insomnia
shuti.me

Online self–guided CBT modules have been pioneered by experts globally, but most notably in Australia by Professor Helen Christensen and Professor Kathy Griffiths through MoodGYM. Launched in the early 2000s, MoodGYM has
4.4 Conducting Therapy in Virtual Worlds

Virtual worlds have come a long way from Dungeons and Dragons. Today, worlds such as Second Life (secondlife.com) and Linden Labs (lindens.com), can be used as locations for online therapy.

The virtual world can provide a private, simulated counselling environment, using avatars (animated characters representing the client and counsellor). Essentially, counselling can occur entirely in the virtual world, using synchronous text or voice at any time of the day or night. The virtual world provides visual experiences as well, which can provide a pleasant and calm environment for the client, or can even be used as a resource stimulus for desensitising therapy for phobias.

Evidence

Virtual worlds have become very popular amongst those who suffer from social phobia [Campbell et al 2006], as well as amongst young people who suffer from intellectual disabilities or long term illness [Laffey, Stichter & Schmidt 2012; Boulos, Hetherington & Wheeler 2007].

Concerns about the use of virtual worlds for counselling or any kind of exposure therapy are similar to those associated with online counselling. They include the legal and risk management obligations of a clinician who may not be able to identify or locate their online client in the real world, unless the client has first disclosed personal information about their true identity, geographic location, next of kin, and so on [Yellowlees, Holloway & Parish 2012].

Despite these limitations, virtual world technology is growing rapidly and has been used since the early 1990s. Many medical and psychological experts believe that, as accessibility and ease of use increases and clear practitioner guidelines for the use of these worlds are developed, virtual worlds will provide positive treatment options for anxiety, depression, and phobias [Demiris 2006] and group counselling for addiction recovery [Boa–Ventura & Saboga–Nunes 2010].

Putting it into practice

| If your service wants to use a virtual world for therapy, ensure your virtual space has clear instructions on what can and can’t be provided to young people in virtual world counselling. |
| The same concerns and issues that apply to e–counselling (chat or email) apply to virtual world counselling. Client identification details need to be obtained and risk management strategies put in place by your service. |
| Access to a virtual world can be 24/7. Without a counsellor or official mediator present, it is important to make sure that online clients respect each other at all times in the virtual world. As in the face–to–face world, clients need to respect each other’s privacy and be respectful to the sensitivities of others. |
| The online virtual world you provide for young people should be engaging, inviting and novel enough for them to want to return. Decorating a virtual world is just as important as providing a comfortable and inviting counselling space in the offline, face–to–face, world. |
| It is important that you have a communication strategy in place in case technical problems occur during a counselling session. The young person must be able to contact you by phone or email so that they know support continues. Disconnects can interrupt sensitive and meaningful moments in therapy. As such, be sure a smooth transition to another communication medium is available instantly at any time. |
| Further advice and evidence about engaging in virtual world therapy can be obtained from Dr Kate Anthony, who specialises in this field of practice kateanthony.net or the International Association of CyberPsychology, Training, and Rehabilitation (iACToR) iactor.ning.com |
VIRTUAL WORLDS

A new form of psychotherapy, Avatar Therapy, has evolved in the online environment. Avatars can engage in role-play as part of a therapy session or simply sit and chat as you would in a face-to-face counselling session. This type of therapy has been found to be particularly useful for social skills training and phobia treatment. Depending on computing and internet speeds, avatars can also use voice – either the user’s own voice or a masked voice.

Murphy (2010) undertook a trial of avatar therapy to determine the pros and cons of this technology. Based on her experience and the available literature, it is clear that this form of therapy is still very much in its infancy, both in terms of its evidence base and client/therapist proficiency.

Murphy reviewed the trials of avatar therapy in virtual worlds for diverse conditions including Asperger’s Syndrome, schizophrenia and traumatic brain injury, but results for managing these disorders were inconclusive. In comparison, smoking, drug and alcohol counselling in virtual worlds, both one-on-one and in a group, is proving to be a good support tool for recovering addicts (Boa-Ventura & Saboga-Nunes 2010; Barretto et al. 2011; Strelzoff, Sulbaran & Ross 2010).
4.5 SERIOUS GAMES

Serious games are video games (PC or console) that have a positive effect on the person using them, either physically or mentally. Popular, off-the-shelf gaming platforms such as Microsoft’s Xbox and Sony’s PlayStation have developed consoles that involve more movement and physical activity as part of game play. Sony developed the Eye Toy™ in 2004 which was the first motion detector introduced to the gaming world. Dance Revolution™ (2003–2004), released as a game for the PlayStation, involved high activity levels and was believed to promote physical exercise in the home. Since this development, motion sensor technology has improved with the released of the Nintendo Wii console, as well as Xbox Kinect – each promoting exergaming to reduce obesity in children.

Other serious game platforms are geared to cognitive exercises. Examples of this are Dr Kawashima’s Brain Training™ for the Nintendo DS, and a large and varied array of popular board-game and card games now translated into mobile phone, handheld and desktop/console games (such as Solitaire, sudoku, etc).

Serious games for behavioural issues are only recently being created, but are faced with the added challenge that their appeal to young people must be as strong as commercial, mainstream, entertainment games. As such, the most successful and popular serious games to date have been ‘exergames’ and brain training. However, the following section describes examples of some serious games used for specific behavioural intervention and mood training with young people.

An Australian example of a serious game delivered via web browser is ReachOut Central (reachoutcentral.com). Developed with the intent to engage young men, ReachOut Central is a serious game that has been designed to improve the mental health and wellbeing of young people (Burns et al. 2010b). An external evaluation found that the game enhances protective factors vital for the prevention or early intervention of mental health problems (Shandley et al. 2010). Young women who participated in the evaluation reported reduced psychological distress and improved life satisfaction, problem-solving and help-seeking; however, no significant changes were observed for young men (Burns et al. 2010b). As an innovative serious game that was cutting edge for its release in 2008, the evaluation results of ReachOut Central, while promising, should be viewed cautiously, due to the use of an open trial methodology and the small number of male participants recruited for the study. The evaluators found that ReachOut Central was effective in attracting young men to the site, but retaining their involvement in the trial was a challenge.

Evidence

Games can be used to promote good mental health. Although the entertainment games industry does not yet manufacture mainstream serious games, many smaller games companies are now working with mental and medical experts to determine therapeutic delivery during game play. For example, Coyle and colleagues (2010) described how games could be developed to target those dealing with eating disorders and other mental health issues. With the advent of serious games as a new format for mental health intervention for young people, a brief overview of evidence-based games currently available is provided.
Obtaining evidence of effectiveness is challenging at present with this new area of research, however the following academic journals review serious games and may be another source of information.

**Depression**

In 2012, the first fantasy–based video game using CBT was produced by the University of Auckland. Merry and colleagues (2012) developed the SPARX, (Smart, Positive, Active, Realistic, X–factor thoughts) computer game which was trialled across primary healthcare centres in New Zealand with 187 young people aged 12 to 19. Results of this innovative study concluded that the game had the potential to be utilised as a complementary tool for the reduction of depression in young people. The study also found the game could be used as a resource to provide young people with information on using CBT to manage depression.

**Attention deficit hyperactivity disorder (ADHD) and anxiety**

Amon and Campbell (2008) conducted a randomised control trial of a biofeedback video game called “Journey to the Wild Divine” (wilddivine.com) as a potential tool to improve attention times and reduce stress, frustration and anxiety in children aged between 6 and 13. The uniqueness of the game intrigued children because its interface did not require a keyboard, joy–stick or control pad of any kind. Instead, children interacted with the game using biological feedback measured by finger sensors, known as ‘rings’, that measured heart rate and skin temperature. The children were asked to complete a task at each level of the game while breathing in a specific way consistently until the task was complete. This consciously and unconsciously taught the children how their breathing controlled their emotions. The study successfully demonstrated that those children with mild to moderate ADHD symptoms could not only control their behaviour, but could apply the techniques learned from playing the game to tasks away from the game, such as school work and frustrating social situations. This study has since been reproduced and the game adapted to treat children with depression and anxiety disorders (Knox et al. 2011).

**Obesity**

MacKinnon and Gardiner (2008) and Jacobs and colleagues (2011) have shown that Wii Fit™ can increase fitness and improve health. Graves and colleagues (2007) concluded that 51 percent more energy expenditure occurs in active games than sedentary games, which is two percent of total weekly energy expenditure. Platforms like Wii Fit™ might therefore contribute to weight management.

How can we use this information to help with the obesity epidemic? McCrady–Spitzer and colleagues (2010) and Jacobs and colleagues (2011) described how behavioural change combined with use of the Wii Fit™ and similar consoles could be an effective method of weight control. Children and adolescents could potentially learn how to manage obesity and related illnesses like diabetes with such technology, but more research is needed about how this could best occur (Talbot 2011).
Another area of research for serious games has focused on games for young people with specific disabilities. Multiple studies have shown how the Wii Fit™ can be used to help those who have suffered from brain injuries (Loureiro et al. 2010; Saposnik et al. 2010). Saposnik et al (2010) suggest that the Wii could be used in combination with conventional therapy. There were also positive outcomes for young people with cerebral palsy (Deutsch et al. 2008) and those with MS (Plow et al. 2011) using Wii Fit™.

A wide spectrum of off–the–shelf video games have been found to benefit individuals with depression and post–traumatic stress disorders. Exergaming using the Wii has shown reduction in depression scores (Caron 2011). Furthermore, exergame activities such as bowling, tennis and baseball have been found to aid those with physical disabilities (e.g. young amputee soldiers) with the sporting pleasure they enjoyed before their injuries, helping to complete rehabilitation without the risk of experiencing the onset of depression.

Putting it into practice

| Serious games should only be recommended if there is an evidence base for specific therapeutic outcomes. |
| Video games, in general, should never be recommended as ‘self–help’ for mental health issues. |
| Parents and teachers should be consulted before offering to introduce a serious game to a child’s treatment plan. This ensures that everyone understands the purpose of the game and the duration of game play recommended by the clinician so as to not give the young person total control over their game playing duration. |
| If you want to recommend a specific serious game, get familiar with it yourself. Make sure you understand its limitations and the game play genre. Some parents may not like first–person–shooter games for example. There may be a more acceptable genre such as fantasy or strategy. |

Case Study

SERIOUS GAMES – RE–MISSION

Hope Labs (hopelab.org) designed and engaged in an international randomised control trial of Re–Mission™. Re–Mission is a video game developed specifically for young people with cancer.

The game is a first–person–shooter, which is a genre that is extremely popular in the mainstream video game market and easy to play for children and young people of all ages. In the game, players pilot a nanobot named Roxxi as she travels through the bodies of fictional cancer patients destroying cancer cells, battling bacterial infections, and managing side effects associated with cancer and cancer treatment. The game has been used in child oncology wards and with outpatients in the USA, Canada and Australia since 2006. In a new version of the game, players can band together and play online.

Evidence for the effectiveness of the game in building coping and resilience of cancer patients undergoing and recovering from the symptoms of chemotherapy is very compelling (Kato et al. 2008).
Technology also opens up new possibilities for involving young people in service design and delivery and in research.

5.1 HEARING FEEDBACK ABOUT TECHNOLOGY

With the growth of web–based technologies, we have an amazing range of options for involving young people in research and in the development of our online services.

Researchers have repeatedly found the internet to be a safe and efficient way to promote research opportunities, inform participants, gain consent to participate and conduct research (Baltar & Brunet 2012; Barchard & Williams 2008; Birnbaum 2010). Become familiar with online tools for research that are both easy for young people to use and that will allow you to analyse the data easily. Research is only useful if it contributes to improving the services you deliver – online and face–to–face.

Online survey tools (such as Survey Monkey) and discussion forums offering focus groups are simple ways to collect information, data and ideas from young people.

Resources for research

Below are examples of basic online research tools a health service provider might consider using for consumer research:

- **Survey Monkey** (surveymonkey.com) is excellent for quantitative and qualitative feedback and typical statistical analyses.
- **Google Drive** (gmail.com) as a shared document editing tool report writing. This is one of the Google tools you can access once you have signed up for a gmail account.
- **Google+** (plus.google.com) is an easy-to-control social network platform you can use to create and engage a research community.
- **Trello** (trello.com) is an online project management tool that interfaces with Google tools.
- **Sharepoint** (sharepoint.microsoft.com) is a space to share information with others and manage documents.
- **Dropbox** (dropbox.com) can be useful for sharing documents such as research articles, that are publicly available (confidential information should not be stored on the cloud).
- **Facebook** (facebook.com) can be used to recruit young people into a research study and for longitudinal studies, and can be useful to maintain contact with them over time.

Evidence

With new technologies emerging at a rapid rate, it is becoming increasingly important that we make wise decisions about where we invest our time and resources. We need to be sure that the technologies we roll out are meaningful and useful for our clients. The research we
are talking about here is about how well the technology we deploy meets the needs of young people. It is very different to the rigorous randomised control trials for efficacy of a technology–based mental health treatment intervention. This kind of research is designed to help us understand how the young person interfaces with the technology. To find out what our users experience, we need to ask:

| Does the technology frustrate you when you use it? |
| Does it make you want to use it regularly? |
| Does it improve your quality of life or peace of mind to know this resource is present? |

Each of these questions may fall into the category of heuristic evaluation – the process of trialling a new software program or hardware technology with a diverse population of users (Fu et al. 2002).

Most web designers and software builders are able to create ICT functions that meet the goals of the health service commissioning them, but very few health services talk directly with the users who are connecting with the technology to receive services. There are, however, tools that can help services understand the user experience better. For example, if a health service is interested in finding out how navigable their website is, software such as MORAE (techsmith.com) can help the service understand how young people access and navigate their website. The software records mouse tracking, time spent on each page and repeated clicks of the mouse. This information can help the service determine whether young people can find what they need quickly and easily.

If you want to conduct research with young people, you need to consider consent issues. Generally, information available in the public domain can be used in research, without consent, if it does not identify participants. However, the lines between public and private information can become blurry online. If information potentially identifies a user, you will need to obtain consent from participants and their parent or guardian if they are under 18 (Spriggs 2010).


**Putting it into practice**

| Before releasing new technology to inform or help young people, consider engaging in a heuristic evaluation of that resource with a reasonably diverse population of users. |
| Consider using online survey and collaboration tools to engage young people in research. This will give them a sense of contributing to the improvement of your service. |
| Research which draws on the ideas, experiences and perspectives of young people can be tricky, but can also be very valuable. |
| Ensure young people understand the purpose of the research, that they can withdraw from the research study at any time without prejudice, and that their privacy is protected at all times. |

**Case Study**

**RESEARCH**

Children First for Health (CFFH) engaged young people to design the format and structure of their website which contained health information (Franck & Nobel 2007). CFFH wanted to move from a very dense and dry website (filled with jargon and marked by a lack of clarity about resources, their availability and their relevance to young people) to a website useful for young people. Young people from five secondary schools completed an internet site navigation exercise, participated in informal discussion with the service staff and filled in a website evaluation questionnaire.

While different participants liked different designs, the service received overwhelming feedback for gender–specific information on topics to do with social skills, fitness and sexual health. The findings highlighted the importance of incorporating young people’s views in the design and function of websites aimed at delivering health information.
YOUTH PARTICIPATION

Biedrzycki and Lawless (2008) researched the ‘Headroom Model’ for engaging young people in participatory research. Several lessons emerged:

| Young people’s participation in research is a journey – a lot of time needs to be invested, both emotionally and logistically, because it is hard to predict how the experiences and the stories from young people will shape both the engagement with the project and the research outcomes. |
| Relationships with young people are the key to a successful project experience and outcome. Relationships need to be respectful and suitably meaningful. Relationships take time and significant skills to build. Using staff who are skilled in communication and are driven to ‘be there’ for young people, regardless of the research project focus, is essential. |
| All levels of an organisation need to be involved in programs promoting youth participation. It’s not just about the project manager or coordinators. This sometimes means the process can be slow, but young people feeling included in the big picture of an organisation is important to their sense of belonging and purpose. |

Seeking young people’s participation in research implies that the organisation is committed to taking care of the young person during the project. Young people’s feedback must be taken seriously and addressed responsibly. If not, the young person will quickly feel devalued and is likely to not continue with the project.

Case Study

YOUTH PARTICIPATION

Biedrzycki and Lawless (2008) researched the ‘Headroom Model’ for engaging young people in participatory research. Several lessons emerged:
5.2 PARTICIPATION IN SERVICE DESIGN AND EVALUATION

Youth participation is a key principle of better practice in youth health services and has been acknowledged by the World Health Organisation as an integral part of youth health service delivery (Quine et al. 2003). The right to participation has been acknowledged by the United Nations’ Convention on the Rights of the Child (1989), which affirms the right to participation for all people up to 18 years of age. As part of our community, young people have a right to express their views and to have them taken into account on matters that affect them.

Services can use technology to encourage youth participation in the design of services. ReachOut.com, for example, uses online discussion and surveys to involve young people in the development, implementation, review and evaluation of their services and programs. This approach gives young people an opportunity to exert personal influence on health service provision and helps to provide a feeling of connection or belonging to that service or program. It also helps build mutual respect between the young person and the service staff.

Evidence

Health service consultation with young people in Australia is generally very inclusive. Organisations such as the Inspire Foundation, Orygen, Kids Helpline, eheadspace, and the Australian Youth Affairs Coalition have engaged youth advisors to undertake service reviews and to help design and evaluate their services regularly. As leading Australian organisations promoting young people’s wellbeing, each organisation sets protocols and measurable outcomes for service reviews, which are informed heavily by the end-user (young people). The inclusion of young people in these reviews is essential: it’s the only way the service can get feedback about the quality of ongoing support and care needs of young people across childhood, teenage and early adolescent years (James 2007).

The Young and Well Cooperative Research Centre published a guide to the Participatory Design of evidence-based online youth mental health promotion, prevention, early intervention and treatment, (Hagen et. al. 2012). This is a resource to guide youth participation in service design. The development of the guide was led by the Inspire Foundation, in partnership with the University of Western Sydney. The guide features case studies exploring the participatory processes used during the development of ReachOut.com and offers a set of tools to facilitate user involvement in the design of different systems, services and products.

Another useful resource, Citizen Me!, developed by the NSW Commission for Children and Young People (2012), assists services to engage children and young people in making decisions about the day-to-day running of the organisation.

Putting it into practice

- Make sure your service has a policy, protocols and procedures in place for appropriate youth participation and consultation.
- Put mechanisms in place to regularly review the effectiveness of your youth participation strategies.
- Ask young people about their experience of participating and if they feel their feedback is being incorporated.
- Support young people to develop the skills they need to participate in the service. For example, you could provide workshops offering training in participating in meetings, facilitating meetings, consulting with other young people and so on.
- Acknowledge young people’s participation and appropriately remunerate them for their expertise in money (where possible) or in kind.
- Make sure that the way you recruit young people to participate recruits for diversity so that many perspectives are heard.
Cyberbullying, or the use of the internet or mobile phones to intimidate, embarrass, discriminate against and/or threaten, is detrimental to young people’s mental health.

Cyberbullying is bullying that occurs over websites, text messages, social networking sites, chat and email messages. It is repeated behaviour that is meant to demean, intimidate, embarrass or harass a young person.

With 91 percent of young people aged 14 to 17 spending time online weekly, cyberbullying is a reality for many young people.

The evidence is growing that cyberbullying produces serious effects for the victim of the behaviour: a sense of social isolation and lack of safety; emotional and physical harm; loss of self-esteem and feelings of shame; mental health issues including anxiety and depression; and concentration and learning difficulties can all accompany the experience of being bullied online. The risk of suicide in young people being bullied is also heightened.

There are many resources that seek to help young people and the organisations that work with young people to deal with and respond to cyberbullying.

6.1 LEGISLATION

- The NSW Crimes Amendment (School Protection) Act provides protection for teachers and students against assault, stalking, harassment and intimidation. This may cover cyberbullying but only if it occurs on school premises or while a person is entering or leaving the school premises.
- Section 31 of the NSW Crimes Act makes it an offence to send threatening documents and likely covers cyberbullying. Other criminal offences and unlawful acts such as assault, stalking, harassment and intimidation may also cover cyberbullying.
- Commonwealth Criminal Codes make it an offence to use telecommunication services to menace, threaten or harass a person and may cover cyberbullying.
- Privacy legislation sets out penalties for breach of privacy and may cover non-consensual posting of visual recordings on websites as part of cyberbullying.

6.2 POLICY

School policies reject all forms of bullying:

- The NSW Department of Education and Communities (2011) has developed the Preventing and Responding to Student Bullying in Schools Policy which applies to all NSW government schools and preschools.
- The Commonwealth has worked with jurisdictions to revise the National Safe Schools Framework (2011) that include a set of guiding principles to help school communities take a proactive whole-school approach to developing effective student safety and wellbeing policies.
Some examples of social media policies include:

- NSW Police’s Social Media Acceptable Use Standards set rules that must be followed by members of the public when they contribute to NSW Police social media sites (Appendix 3).

- NSW Department of Education and Community Social Media Policy has been developed to provide department employees with standards of use as they engage in conversations or interactions using digital media for official, professional and personal use (Appendix 4).

### 6.3 HELP AND COMPLAINT LINES

Young people who have been bullied or who have witnessed others being bullied can contact:

- **Kids Helpline (1800 55 1800)** is a free and confidential, telephone counselling service for 5 to 25-year-olds in Australia. [kidshelp.com.au](http://kidshelp.com.au)
- **Lifeline (13 11 14)** is a free and confidential service staffed by trained telephone counsellors. [lifeline.org.au](http://lifeline.org.au)
- **eheadspace** is a confidential, free, anonymous, secure space where young people can chat with or email qualified youth mental health professionals. [eheadspace.org.au](http://eheadspace.org.au)
- **ReachOut.com** is an online community for young people that can help with mental health and wellbeing-related issues. It also provides opportunities for connecting with young people. [reachout.com](http://reachout.com)

### 6.4 RESOURCES

There are several commonwealth and government sponsored websites presenting guidelines and assistance for teachers, parents and students to prevent and/or respond to cyberbullying:

- The Cybersafety Help Button is an online resource hub that gives young people instant access to help and information on cybersafety issues. When the button is clicked, users are taken directly to a web page where they can talk, report or learn about cybersafety issues. It can be downloaded at [dbcde.gov.au/online_safety_and_security](http://dbcde.gov.au/online_safety_and_security)
- The Commonwealth Government’s Cybersmart website has a range of information and resources on online safety, accessible at [cybersmart.gov.au](http://cybersmart.gov.au)
- Public schools in NSW are provided with the resource ‘Taking Action, Keeping Safe’ (2005) which provides strategies and support materials for student leaders and teachers to increase students’ knowledge and understanding of bullying. Find it at [schools.nsw.edu.au](http://schools.nsw.edu.au)
The NSW Department of Education and Communities provides advice on cybersafety; information on risks; online games to help students work out how to stay out of trouble; and a quiz to help students confirm if they are being cyberbullied. The Department has developed a resource entitled ‘Cyberbullying: Information for Staff in Schools’ (no date) which identifies the impacts of cyberbullying and provides practical responses for teachers. It’s available from [det.nsw.gov.au/policies](http://det.nsw.gov.au/policies)

Schoolatoz – The NSW Department of Education and Communities has also established a website aimed at parents and children which provides articles and instructional videos on cyberbullying. Visit [schoolatoz.nsw.edu.au](http://schoolatoz.nsw.edu.au)

Childnet International – a multimedia cybersafety training program for teachers, parents and young people developed in consultation with young people. Visit [childnet.com](http://childnet.com)

ThinkUknow cybersafety education program – delivers interactive training to parents, carers and teachers through primary and secondary schools. Find the program at [thinkuknow.org.au](http://thinkuknow.org.au)

The Alannah and Madeline’s eSmart program – an evidence-based and tested system to help schools manage cybersafety and deal with cyberbullying and bullying. Visit [esmartschools.org.au](http://esmartschools.org.au)

Skoodle is a safe social network where 6 to 14-year-olds experience firsthand how to keep themselves safe online. Find it at [skoodle.com](http://skoodle.com)

**Putting it into practice**

The Australian Youth Affairs Coalition’s policy on Technology and Cybersafety (2012) recommends:

- The growth of digital technologies is an overwhelmingly positive trend and should be employed to deliver services that benefit young people and facilitate their economic, social and political participation in society.
- Responses to cybersafety issues should start by trusting and empowering young people themselves as experts on their own use of technology.
- Cybersafety solutions should be based on youth-centred research and consultation on how young people use technology and their own views and strategies for managing risk.
- Governments must approach cybersafety with evidence-based responses to cybersafety, rather than those based on hype or stereotypes.
- Education programs for parents, educators and policy-makers should promote appropriate action and a clear understanding of cyber risks.
- To promote safety and wellbeing in digital contexts, young people should be supported to develop their broader critical literacy skills, and social and emotional learning.
- All young people should be supported to develop their media and technological literacy.
- Equitable access to digital technologies – especially for the most disadvantaged young people – is critical for young people’s social and economic inclusion.
- The youth support sector needs to incorporate digital technologies into their work with young people, especially in delivering programs and services to rural and regional areas.
BOUNDARIES OF SERVICE RESPONSIBILITY – REACHOUT.COM DUTY OF CARE FRAMEWORK

In all its online spaces where ReachOut.com engages young people, a statement clearly outlines the extent of what services are and are not provided. The guidelines have been developed with young people and align with the ReachOut.com Duty of Care policy – ensuring they are both comprehensive and easy to understand.

Guidelines clearly define the different kind of activities that are appropriate. For example, on ReachOut.com’s Facebook page, guidelines state that the page is a space to talk about the mental health and wellbeing of young people, and that it is not a place to get one-on-one help, counselling or crisis support. Guidelines for the ReachOut.com forums are different, clearly identifying them as a space for peer support and positive discussion of issues related to mental health and wellbeing. In this space, the guidelines specify that young people should not give medical advice to others, but instead share what has worked for them. In addition, the guidelines specify acceptable and unacceptable behaviour and language.

The sites also provide the contact details of appropriate crisis support and counselling services and emergency services.

Managing risk in anonymous forums

Anonymity provides young people with the safety and security to open up and discuss issues they are facing. On the ReachOut.com website, risk is managed via three strategies: technical measures, self-moderation and staff moderation.

**Technical measures:**
- Users must sign in with a member account if they wish to write or submit a comment or forum post.
- Personal information is not disclosed to the public via membership accounts.
- Software automatically detects a broad range of ‘alert words or phrases’ and sends a notification to staff, highlighting potentially inappropriate or harmful posts.

**Self-moderation:**
- All users must adhere to community guidelines which establish appropriate/inappropriate behaviour and the limitations of the services provided by ReachOut.com.
- Young people can report inappropriate or risky content to moderators by clicking on the report button.

**Staff moderation:**
- Trained peer moderators monitor the community and facilitate community discussion, hiding or reporting risky or inappropriate content in accordance with the forum guidelines.
Staff moderators respond to distressed young people and difficult content. Discussions about sensitive issues or more serious mental health problems are facilitated by youth workers and mental health professionals. If a young person posts information that indicates intent to suicide or cause harm to themselves or others, or raises child protection issues, staff follow set escalation procedures.

In order to avoid contributing to stigma by appearing to silence the voices of young people reaching out for help, staff moderate only when essential and where it is considered the content may cause harm to the young person or others.

Managing risk on Facebook

Discussions facilitated on Facebook are different to those held in the ReachOut.com forums. Due to the more public, less anonymous nature of these spaces, discussions are kept to lighter, less sensitive topics and focus on mental health promotion, wellbeing and resilience. Content and discussions on the ReachOut.com Facebook page encourage young people to share skills and strategies that help them build on strengths and deal with everyday issues such as stress, relationships and bullying. Guidelines explicitly state that posts will be removed if they contain harmful or inappropriate advice, detailed discussions of self-harm or suicide etc.

It is clearly stated that ReachOut.com does not provide one–on–one advice or support, and the guidelines provide information about where to get help. Young people are directed to the ReachOut.com forums or professional support services when they post or discuss more sensitive topics. Users are encouraged to use the Facebook reporting functionality for posts (other than on the ReachOut.com page) which discuss suicide. In the event a young person discloses to ReachOut.com information that suggests intent to harm themselves or others, the issue is escalated in accordance with the ReachOut.com Duty of Care policy.
Escalation process

- When a young person is at risk of harm or discloses potentially serious information, there is a defined escalation process that must be followed.
- On first sight, moderators respond and provide referrals to appropriate crisis support services such as Lifeline or Kids Helpline.
- Moderators hide the post if necessary, and report the situation to the Online Community Coordinator.
- If the situation is serious and involves suicide, self-harm, serious mental health concerns, or child protection issues, it is escalated to the Support Group, a small working group comprising staff who are appropriately skilled to implement and monitor the Inspire Foundation’s Duty of Care framework.
- The Support Group consults and develops an appropriate response to the post.
- In exceptional situations, the Support Group escalates the issue to the CEO or the Clinical Advisory Board, comprising experts in child and adolescent mental health, for assistance and/or response.
- Internal procedures for monitoring ReachOut.com’s online spaces ensure that high-risk comments are escalated within a maximum of 24 hours, with more rapid response times within business hours.

Responding to disclosures about suicide

If a young person discloses that they are experiencing suicidal ideation or engaging in suicidal behaviour, a risk assessment is conducted by the Support Group to determine the severity of the situation. This risk assessment includes reviewing historical content provided by the young person to identify the presence of risks such as a well-developed suicide plan, access to means of suicide, and any history of suicidal ideation and behaviour, as well as protective factors such as strong support networks and coping mechanisms.

On the basis of this risk assessment, a decision is made about whether or not to contact emergency services. This decision is also informed by the amount of identifying information that can be gathered including IP address and email address. The Inspire Foundation has established a relationship with NSW Police which allows for simple and direct reporting of the situation.
INTERVIEW WITH BROOKE SACHS FROM HELLOMEDICAL

Do you believe young people are aware that online health service providers (be they organisations or individuals) need to gain information on them to ensure their safety in a crisis (e.g. not turning up to an online counselling session)?

I haven’t heard of young people complaining of information being required of them, nor of any informational campaigns that have suggested personal details would be required when signing up for an online mental health or physical health service. While I am personally aware of the liability and safety reasons for an organisation like headspace to take personal information before consulting with a young person (or any person at all), I’m not sure that this is common knowledge. If campaigns to get young people to use these services focused on this introductory process, I think it could deter a lot of young people from accessing the service at all. If, on the other hand, a young person hears of headspace and thinks it would be useful for them, the information they must provide in order to get to the thing they want (online counselling) is less of an imposition because they’re mentally already signed up. While some young people might be deterred at this final stage, I think the proportion would be fewer than if it was part of a TV commercial.

Once contacting an online health service, do you believe young people are aware that details collected on them (both for health records and safety/risk management interventions) are private and safely recorded?

While there is now a lot of awareness about Facebook, Twitter and other social media platforms having access and rights to information we post there, I think a lot of young people are unaware of what that means. In the case of social media, very few people are likely to leave a platform that can link them to almost everyone important in their lives ... regardless of the amount of information they are handing over. As long as that service makes life easier, people will continue to use it. By the same token, when engaging with help services, young people are more interested in what’s in it for them – will this service help me feel happy again? I think the first part of this question – are young people aware their information is collected – is important to ask before they know if it is then stored safely.

In regards to safe storage, it is my impression that big organisations are generally trusted to keep information safe (regardless of whether this is what they do). I would question whether methods of storage need to be made particularly clear to the average user. It would be great, of course, to have the information available in a ‘find out more’ link but it could be overwhelming when someone just wants to get help for how they’re feeling right now. All of these extra considerations could act as a barrier to care.

Do you believe young people understand that online health service providers are limited in their effect for serious health/mental health problems, if they are not willing to seek face–to–face help after online consultation/support?

It may not initially be clear that an online service won’t solve everything. It may be good to make young people more aware that the best form of help is in person, engaging with multiple services and groups. I feel that young people may come to a point in their online care where they feel it is not fulfilling their needs and hopefully that would be the point where they seek out face-to-face care. It may not be something they realise prior to undertaking online care, as the online world fulfils so many needs of young people as it is.
INTERVIEW WITH DAN CONIFER FROM NSW YOUTH ADVISORY COUNCIL

In your opinion, what would be the most engaging technology function for young people to commence seeking help for a mental health problem?

Social media and social networking (e.g. Facebook, Twitter, YouTube).

In relation to the above, why do you think that is the most popular?

Facebook, and also Twitter and YouTube, would allow access to the largest amount of young people. Most young people would have an account on one or more of these platforms. These technologies are largely used in private, thus reducing social stigma. Young people also use these regularly, because of the social pressure to remain active on these sites (e.g. posting statuses, commenting), and because they are available online, on smartphone, and on tablet computers (among other devices).

What are some of the ways Facebook could be used to engage young people?

Use Facebook ads to directly tell young people about organisations and services. These ads can be fairly targeted, allowing an organisation to target young people who live or work in a certain area, or are a certain age. Facebook ads are targeted based on usage, which may allow targeting toward young people who have discussed or searched mental–health related material on Facebook, or online. These are good, because clicking an ad is anonymous, opposed to liking or commenting on a Facebook post. For example, a Facebook ad could promote the Australian Psychological Society’s ‘find a psychologist’ service.

Create a Facebook page: subtly pushing message about services. First get people to like the page. Once a page is established, it has to be heavily promoted through networks in the initial stages. Pages can also be advertised through Facebook ads. Liking the page can be incentivised through competitions.

The focus is on keeping people engaged with the page. Content must be updated daily at the very least. Frequent updating is important as the message might be missed depending what time of day they log on. Varying statuses is important so young people don’t feel like the content is repetitive or boring.

To ensure constant flow of content, statuses can be pre–programmed using software such as Tweetdeck. Content from other organisations, or news about mental health and/or young people, could be used to fill content on these pages.

Facebook pages also have a private messaging function, which could be a good way for young people to ask organisations for advice, whether they are the right organisation for them, and if not, who would be. The advantage of a ‘friend’ page is that the ‘chat’ function is available, allowing instant messaging between the organisation and the young person.

What should be posted?

First, posts people want to share. Posts have to be shareable – entertaining or interesting enough for someone to share it with their friends. For this purpose (i.e. sharing), I would be reluctant to post something simple, like ‘Feeling down? XYZ counselling can help’. I would more likely post a video or story, with that message behind it. or example, an inspiring video or article about a young person who has overcome a mental health disorder to achieve great things in their life, with that message in the scripting, or at the end of the video/article.
For young people to share things with their friends online, I would say content should not be too heavy, rather it should be easy to access, and interesting. I see this both as non-confrontational and off-putting for a young person in the short term, and also a way to reduce stigma and open dialogue around youth mental health in the long term.

Second, posts that generate discussion. Facebook pages or mental health organisations could post statuses not related to mental health to generate discussion on the page. This could make young people increasingly comfortable with the brand of that organisation.

Also consider getting support from a famous person. Famous individuals whose pages have a lot of likes on Facebook, or followers on Twitter, could be recruited to post about mental health organisations and their activities.

Lastly, how can services improve – technology wise – in regards to getting more young people to access them and feeling supported by them?

Some of the good things include:

- An attractive website makes you want to stay on the pages and look at different parts of the site.
- Twitter has regular updates.
- Facebook used an online news article to get traffic flowing to their website and its information. E.g. “An important article about young men and body image. If you want more info or details on how to get help around body image & eating disorders check out our website: headspace.org.au/is-it-just-me/find-information/eating-disorders”
- Emergency help link at the top of the page is good, giving info about different counselling services available immediately.
- The fact sheets and stories were easy to find and clearly distinguished between different mental health problems.
- Facebook page is cool and funny, and somewhere I’d be more inclined to visit.
- Giving the options of phone counselling, web counselling or email counselling as soon as people get on the page. Good cover photo at the top of the Facebook page with a number to call and email address; clear and obvious.

Things that could be improved:

- The messages in the videos need to connect with me – a lot of videos seem scripted and clichéd, and read by those not in the youth demographic.
- The ‘getting help’ part of sites needs to be prominent.
- Some of the posts on social media sites seem irrelevant to everyday young people.
- If a website looks around five years old – it would not appeal to young people.
- Too much info on the homepage – I don’t know where to look or go. Information has to be laid out clearly on the webpage.
- Facebook, Twitter and YouTube links aren’t prominent enough on a website.
- Facebook and Twitter don’t have the quantity of posts required to drive traffic to the site.
- Include videos on the website.
- It needs to be clear how people could seek help directly from the website, Facebook page etc. Kids Helpline do this well (see below), as do ReachOut.com (with its emergency button).

Overall, from looking at a number of organisation’s websites and social media pages, what young people with a mental health problem would want to know is: What am I feeling? Am I alone? Are there others like me? How did they get better? And how can I fix it?
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Using technologies safely and effectively to promote young people’s wellbeing


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APPENDIX 1 TWITTER MENTAL HEALTH HASHTAGS

Many organisations and individuals use Twitter to share mental health information with a much wider network. Use the search function in Twitter to find hashtags (Kiume, 2010).

Most tags can be used to find relevant tweets at any time, but some are used for weekly for Tweetchat events like #mentalhealthmonday, and chats on different topics. For example:

#mhsm Mental Health and Social Media chat (Tuesdays 9:00 pm EST), @MHSMchat
#ojtl Our Journey Through Life family / friends support chat (Thursdays 9:00 pm CST), @OJTLblog
#ppdchat Post–partum depression chat (Mondays 1:00 pm and 8:30 pm EST)
#peersupport Mental health

Many tags are focused on a specific mental health issue. However using popular, short hashtags, means info reaches more readers, gets re–tweeted, and connects more activists than specialised tags. #endstigma has been suggested as a new gathering place, and #mentalhealth is one that’s already commonly used.

Below is a popular list of existing tags:

#abuse abusive behaviours, or substance abuse
#add or #adhd attention deficit and (hyperactivity) disorder
#addict #addiction or #addictions various addictions (substances also have hashtags)
#anxiety anxiety
#asd or #autism autism spectrum disorders
#aspie Asperger’s Syndrome
#attitude positive attitude
#bipolar bipolar disorders
#bodyimage body image
#borderline or #bpd borderline personality disorder
#bullying anti–bullying
#chronicpain chronic pain
#coping coping skills
#cutting self–injury
#cyberbullying against online bullying
#depression clinical depression
#did dissociative identity disorder
#dv domestic violence
#eatingdisorder eating disorders
#empathy empathy
#endstigma end mental health stigma campaign
#epatient e–patient info
#grateful what are you grateful for?
#hcsm health care and social media
#hugsnotdrugs drug abuse prevention
#madpride Mad Pride
#mentalhealth mental health, general (high volume)
#mentalillness mental illness
#mentalhealthhero profiles of mental health professionals
#neuroscience brain science
APPENDIX 2 EVALUATING ICT PRODUCTS

Heuristic evaluation questionnaire

The following is a standard heuristic evaluation questionnaire by Donn De Board (2004) that can be utilised online to gain a consumer base understanding of functionality and ease of use of ICT products developed by a health service provider.

Each question should be rated:
Very Unsatisfied......1......2......3......4......5......Very Satisfied
Severity Ranking......Low ......Moderate......High......Question is Not Applicable......
Following this each section should be totalled and evaluator comments recorded.

Effective

(What is the completeness and accuracy of your work? What percent of your goals were reached successfully? How well was a task completed?)

1. Is it clear where on the screen to find the help system?
2. Is it clear how to begin to use the help system? (Is it obvious how to invoke the help?)
3. Is it clear how to exit help system at any time?
4. Can you change the level of available detail in the help system?
5. Can you easily switch between the help system and your work using (your software application)?
6. Is the help non–intrusive (invoked only when the user requests it)?
   (The Help should not distract the user’s attention from their work before being invoked.)
7. Can you resume your work where you left off from accessing help?

Efficient

(The speed and accuracy of your work? How quickly did you reach your goals? How quickly was a task completed?)

1. Are there various access methods in the help system (Table of Contents, Index, and hyperlinks) that enable you to find information quickly and easily?
2. Context / Purpose: Does the information in the help system answer why a given task is necessary? (Is it context–specific?)
3. Navigation: Is the information in the help system easy to find?
4. Is the information in the help system navigational (Where am I?)?
5. Is additional information in the help system available (What information related to this topic)?
6. Does the information in the help system point you to the next task in a workflow?
7. Is there an example in the help system for you to reference, as needed?
8. Does the help system provide an overview of the work process you perform?
9. Does the help system assist you in defining your workflow using (your software application) and the related tasks involved in that work?)
Engaging

(How distinct and consistent is the visual presentation, graphic images, and colors? How clear and distinct is the design and readability of text on screen?)

1. Presentation: Is the visual layout in the help system clear and distinct? Are there visual cues that help identify information and its use?
2. Conversation: Does the information seem complete and understandable? (Information is assumed to be accurate, based on current information at time of help development.)
3. Is the information in the help system goal-oriented? (What can I do with [your software application]?)
4. Is the information in the help system descriptive? (What is this [your software application] module for?)
5. Is the information in the help system procedural? (How do I do this task?)
6. Is the information in the help system interpretive? (Why did this happen?)
7. Is the information in the help system easily available? (Help is available within one or two clicks.
8. Reader does not need to rummage through help topics?

Error tolerant

(Does the help system prevent the user from making errors? Is there information on how to recover from errors?)

1. Are there cautions and warnings in the help systems that keep you aware and away from trouble using (your software application)?
2. Is there a troubleshooting section of the help system that provides a remedial course of action if something unexpected occurs while using (your software application)?
3. Is this troubleshooting section easy to find?

Easy to learn

(Is the help system predictable? Can anyone use the help system with confidence, given a basic skill set required to use [your software application]?)

1. Is the help system navigation consistent with the navigation interface of the (your software application)?
2. Is the help system presentation consistent with the presentation interface of (your software application)?
3. Is the terminology (terms, concepts, etc.) in the help system consistent with the terminology used in (your software application)?
4. Does the help system have shortcuts or ways to support people with varying levels of knowledge or a familiarity with the help system?
5. Does the help system encourage you to learn and perform complex tasks by providing cue cards, coaches, or wizards?)
Section 5.3 Acceptable Use Standards

The aim of the Acceptable Use Standards is to set rules that must be followed by members of the public when they contribute to police social media sites. The Acceptable Use Standards help to create an environment where community members can contribute their views to assist the NSW Police Force or improve police policy or services, without fear of abuse or harassment or exposure to offensive or otherwise inappropriate content. The standards also protect the NSW Police Force from legal liability.

All official NSW Police Force social media sites that seek public comments online must have the following Acceptable Use Standards displayed on the site:

When contributing your views to this forum, please ensure that you:

| Protect your personal privacy and that of others by not including personal information of either yourself or of others in your posts to the forum, (such as names, email addresses, private addresses or phone numbers) |
| Report information about crime or persons of interest directly to crime stoppers or a police station, not to this site |
| Post material to the forum that is relevant to the issues currently being discussed |
| Represent your own views and not impersonate or falsely represent any other person or organisation |
| Do not post material or use language that is obscene, offensive, indecent, pornographic, insulting, provocative, or harass, intimidate or threaten others |
| Do not use language that incites hatred based on race, gender, religion, nationality, sexuality or other personal characteristic do not post material that encourages behaviour that may constitute a criminal offence or create a civil liability, or otherwise violate a law |
| Do not post or upload any content that is unlawful, is in contempt of court or breaches a court injunction, or may defame, libel or discriminate against others |
| Do not post material that is prejudicial or pre–judges a person who has been arrested and charged, but who has not yet had the opportunity of defending themselves in court |
| Do not post material to the forum that infringes copyright, trademark or other intellectual property rights |
| Do not post multiple versions of the same view to the forum (spam) |
| Do not promote commercial interests in your posts to the forum; and |
| Do not include internet addresses or links to non–government department websites, or any email addresses, in your contribution |

Postings which breach the Acceptable Use Standards may be deleted or the author banned from this site. In extreme case breaches may result in criminal or civil sanctions.
This policy has been developed to provide department employees with standards of use as they engage in conversations or interactions using digital media for official, professional and personal use.

1. Objectives – Policy statement

1.1 The department supports its employees’ participation in social media online applications such as social networking sites, wikis, blogs, microblogs, video and audio sharing sites and message boards that allow people to easily publish, share and discuss content.

1.2 Social media provides an opportunity to:
1.2.1 Engage and interact with our various audiences.
1.2.2 Promote staff expertise.

1.3 The following five standards apply to employees’ work use and personal use of social media at any time, when it has a clear and close connection with the department. The department will enforce these five standards as and when appropriate:
1.3.1 Always follow relevant department policies including the Code of Conduct.
1.3.2 Do not act unlawfully (such as breaching copyright) when using social media.
1.3.3 Make sure your personal online activities do not interfere with the performance of your job.
1.3.4 Be clear that your personal views are yours, and not necessarily the views of the department.
1.3.5 Do not disclose confidential information obtained through work.

2. Audience and applicability

2.1 The terms and conditions contained in this policy document apply to all department employees including staff in schools and TAFE, Adult Migrant English Service (AMES) employees, and all casual, temporary and contract staff.

3. Context

3.1 Use of web 2.0 technologies / social media is increasingly part of everyday online activities.

3.2 This policy should be read and interpreted in conjunction with:
Code of conduct
Online Communication Services : Acceptable Usage for School Students
TAFE Use of internet and Intranet Services (Intranet only)
Online Communication Services – Acceptable Usage – TAFE NSW Employer Communications Devices Staff Use Policy
Copyright (intranet only)
Media Relations Policy
NSW Public Schools Values
Controversial Issues in Schools Policy
Social Media and Technology Guide for Staff (intranet only)
3.3 Document history and details

4. Responsibilities and delegations
4.1 Senior executive and workplace managers are required to ensure this policy is understood by staff working within their area of control.

5. Monitoring, evaluation and reporting requirements
5.1 The director, corporate communication directorate is responsible for monitoring and evaluating the effectiveness of the policy.

6. Contact
Director, corporate communication directorate
(02) 9561 8088