

A Rural Youth Consumer Perspective of Technology to Enhance Face-to-Face Mental Health Services

Simone Orlowski^{1,2} · Sharon Lawn¹ · Gaston Antezana^{1,2} · Anthony Venning¹ · Megan Winsall^{1,2} · Niranjana Bidargaddi^{1,2} · Ben Matthews³

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Abstract The imbalance between need and available resources with respect to youth mental ill-health has encouraged a growing body of literature around technology to support existing face-to-face services. However, this literature has not adequately investigated the perspective of youth as consumers and no data exists on the views of rural youth. In response to this gap, in-depth qualitative study investigated the perspectives of rural youth who were currently seeking help at a mental health service. Semi-structured interviews were carried out with a clinical sample of 10 young people (5 female), aged 16–22 years. Participants were recruited from two different mental health services located in two rural South Australian regions. Data were analysed via inductive thematic analysis. Results highlighted a young person's desire for self-determination around their health and help-seeking within a service current environment that systematically subverts it. Overall, participants had long and complex histories of help-seeking associated with a history of isolation, disadvantage and trauma. A strong need for personal connection in the context of help-seeking was evident. Preferences for, and actual use of, the internet for mental healthcare existed on a continuum from no current (or future desire) to use technologies through to active interest in, and current use

of, technologies as an adjunct to face-to-face care. Limited financial and infrastructural resourcing made it more difficult to access help online. Understanding and actively seeking out these views in design and implementation of technologies is in line with the current shift toward more consumer-focused and inclusive service design and delivery.

Keywords Youth · Mental health · Rural · Technology · Services

Introduction

The internet is now viewed as a way of life for young people with the large majority reporting regular access and use. While using the internet to connect with others is the primary reason young people go online (Abs 2011), information seeking is another major use (Cave et al. 2015). Considering the large disease burden mental illness currently presents to young people (aged 16–24 years) (Kessler et al. 2007; Slade et al. 2009) the emergence of technology-supported approaches to mental health care represents a major breakthrough in how services can be delivered. Current technological health applications can be grouped into four main functions: (1) information provision; (2) screening; (3) assessment; and (4) monitoring, with the bulk of these applications aimed at adults suffering anxiety and depression (Lal and Adair 2014). As young people are now seeking health and mental health related information online (Burns et al. 2013; Oh et al. 2009), the internet as a medium through which cost effective, anonymous, accessible and flexible health services can be delivered is now a legitimate reality (Lal and Adair 2014).

✉ Simone Orlowski
simone.orkowski@flinders.edu.au

¹ Flinders Human Behaviour and Health Research Unit, Margaret Tobin Centre, FMC, Flinders University, Sturt Road, Bedford Park, Adelaide, SA 5042, Australia

² Young and Well, Cooperative Research Centre, Abbotsford, VIC, Australia

³ School of Information Technology and Electrical Engineering, University of Queensland, Brisbane, Australia

Numerous standalone mental health focused technologies exist—such as online Cognitive Behavioural programs for depression and anxiety (Calear et al. 2013) and virtual clinics (Klein et al. 2011; Titov et al. 2015)—along with a growing body of literature around use of technology within existing face-to-face mental health services (Reynolds et al. 2015; Wentzel et al. 2016). With this in mind, it is believed that the judicious use of technologies in the area of mental health support may assist in increasing the historically low youth engagement with mental health services, as they offer an unprecedented opportunity to provide services in a manner congruent with many young peoples' experience of the world (Burns and Birrell 2014; Christensen and Hickie 2010). Given that increased youth engagement with services has been linked to improved consumer outcomes (Schley et al. 2012) it is crucial that we understand more about how technologies can add value to face-to-face mental health services. For example, the use of technology to support face-to-face mental health practice could deliver more personalised and standardised treatment, and it may help facilitate speedier recovery and prediction and prevention of relapse. This is possible in part, through predictive analytics, increased consumer input and self-management and more inclusive stakeholder communication (Reynolds et al. 2015; Wentzel et al. 2016). Currently, however, the use of technologies to support face-to-face services is under-researched (Montague et al. 2014).

Rural youth are a group of young people who ostensibly stand to benefit the most from technology-supported services. It has been reported that those who live in rural areas experience poorer health, lower life expectancy, greater delays in accessing services and are more likely to engage in negative health behaviours than those living in metropolitan locations (Australian Institute of Health and Welfare 2005; Green et al. 2012). The true impact of rural living on mental health and level of difference between rural and metropolitan mental health service usage, however, remains difficult to determine due to methodological differences and inadequacies in the current literature (Black et al. 2012; Boyd et al. 2000; Boyd et al. 2011; Eckert et al. 2004; Green et al. 2012; Hardy et al. 2011; Judd et al. 2001; Newton et al. 2010; Perkins et al. 2013; Sawyer et al. 2001). In contrast, rural youth perspectives around barriers to mental health help-seeking are well understood. Reported structural barriers include lack of reliable transport, youth mental health specialists, and out-of-hours support, along with perceptions of long wait-lists. Contextual barriers include the social visibility and lack of anonymity that comes with living in rural location and the associated fear of gossip, stigma and social exclusion (Aisbett et al. 2007; Boyd et al. 2007). More broadly, a general preference for informal help (Hickie et al. 2007;

Rickwood et al. 2007), a culture of self-reliance (Boyd et al. 2007) and difficulties with symptom recognition and low service awareness (Smith 2012) negatively impact on youth help-seeking.

The fact that young people prefer to seek help from informal sources is not surprising given that previous research has suggested that interaction with the formal mental health system is akin to negotiating a maze (Emmerson et al. 2004). Indeed, Websters' (2008) research with young Australian mental health consumers (aged 18–25 years) describes the process of seeking help as “finding a way” in that getting the right help at the right time is not a straightforward process or a foregone conclusion by any means. As such, information communication technologies are held up as having enormous promise in assisting consumers to better navigate, and/or in redesigning, the currently broken mental health system (National Mental Health 2014).

Whilst the literature is scant around examples of technology as an adjunct to face-to-face mental health service provision, current research suggests that technology can play a crucial role in generating services that better meet consumers' needs. For example, the use of electronic health tools has been shown to assist with increased rates of disclosure of sensitive issues to mental health professionals and time efficiency within a face-to-face therapy context (Bradford and Rickwood 2015). Similarly, the case for using telehealth/psychiatry to deliver specialist services to rural young people who otherwise would not receive them is compelling (Gloff et al. 2015; Wood et al. 2012). This research challenges mental health workforce fears that are commonly associated with technology-supported services such as concerns around privacy, confidentiality, increased workload and possible disengagement from face-to-face therapy (Doherty et al. 2010; Matthews and Doherty 2011; Wadley et al. 2013)

The rhetoric around technology's perceived ability to enhance services must also be balanced by a consideration of alternative perspectives and experiences. Whilst technology-based tools show promise in a face-to-face service delivery context, the numbers of young people indicating a preference to seek help via the internet is not as high as conventional wisdom would suggest. In response to a self-report questionnaire, the large majority of Australian young people (aged 15–19 years) indicated they would prefer to seek help from face-to-face services or not at all, with only 16 % expressing a preference for online treatment (Wetterlin et al. 2014). Moreover, the seemingly ubiquitous nature of information communication technologies and the narrative around youth as ‘digital natives’ can obscure the fact that many young people do not have access to the internet or related technologies due to unavailability of hardware, connection or download capacity for financial or

geographical reasons (Newman et al. 2012). This limited access, be it extent, frequency or quality, is associated with a cycle that reinforces disadvantage, particularly in the context of the push toward access to services, support and information via information communication technologies (Baum et al. 2014).

While the view of the mental health workforce around technology-supported face-to-face services is well represented in the literature (Blanchard et al. 2012; McMinn et al. 2011; Montague et al. 2014), previous research has not adequately investigated youth consumers' perspectives (Montague et al. 2014). No data exists on the views of rural youth while they were experiencing mental health problems. In response to this gap, our in-depth qualitative study investigated the perspectives of rural youth who were currently seeking help at a mental health service. As such it explored a youth's experience of the current mental health system, their personal experiences of mental ill-health and help-seeking in a rural context, and their views around how (and indeed if) technology can assist themselves and other young people to experience better quality help when and where they need it.

Method

Participants

Data were collected from a clinical sample of young people who were currently seeking help for a mental health condition. In total, 10 participants (5 female) aged 16–22 years were recruited throughout mid 2014—early 2015. Participants were recruited from two mental health services located in two inner rural regions in South Australia (refer to Table one for reasons support was sought). See Table 1 for further descriptive data around participants. The study received ethical clearance from the South Australian Department of Health Human Research Ethics Committee

Table 1 Participant demographic information

Number	Gender	Age	Reason(s) for seeking help
1	F	22	Depression, social anxiety, bi-polar
2	F	18	Trauma, depression, anxiety
3	M	17	Anxiety
4	M	19	Anxiety/depression
5	M	17	Recent trauma (family suicide), anxiety
6	M	22	Anxiety/depression
7	F	16	Anxiety/depression
8	M	17	Anger-related issues
9	F	16	Psychotic symptoms
10	F	22	Depression

(HREC/14/SAH/34). Purposive sampling was used in order to equally sample the wide the range of views present in the 16–24 age group and to obtain an equal gender representation. Sample size was determined when saturation of ideas was reached, as determined by the research team during data analysis discussions (Rennie et al. 1988).

Procedure

In-depth semi-structured interviews were undertaken. The interviews lasted between 1 and 1.5 h in length. Participants were recruited through youth mental health professionals from two different services that had taken part in an earlier stage of the larger research project. Mental health professionals were given a promotional flyer for the project, participant information sheet and consent form, and asked to approach clients to participate in the study. The clients approached were ones who they believed were suitable (i.e. low risk and well-engaged with the service) and interested in discussing their experiences of struggling with a mental health condition, help-seeking and the role of technology within this. Upon a young person's indication of interest, (with the participants' approval) the first author contacted the participant and set up a time and location for the interview. Interviews took place in a location convenient for the participants which was generally in their region of residence. Participants were given the choice as to whether they wished their mental health worker to be present for the interview; five participants chose to take this offer up. One participant chose to have their grandmother and partner present. At the beginning of interview, participants were informed of the purpose of the study and that it would be audio recorded and transcribed verbatim. All participants signed a consent form. Participants received a \$30 voucher for their participation in the study. Please see appendix 1 for the interview schedule which was developed iteratively as participant responses necessitated change, either to remove unnecessary questions or add questions where new lines of investigation became apparent.

Data Analyses

Interviews were professionally transcribed (and checked for accuracy by the first author). Transcripts were then analysed using inductive thematic analysis (Braun and Clarke 2006) using NVivo software (NVivo Qualitative Data Analysis Software 2012). The analytic process described by Braun and Clarke's (2006) was adapted for the current purpose. Initially, the process involved: (1) Reading and re-reading of transcripts; (2) Generation of initial codes; (3) Searching for themes; and (4) Reviewing themes and production of a thematic map. To increase the

validity of the results, steps 1–4 were independently carried out by the first and third author. The resultant thematic maps were then compared for consistency and an overall map was produced. The first author then carried out Step 5. Defining and naming themes—the final themes aimed to represent the various interpretations of the data. The second author then provided a logic check regarding finalisation and parsimony of the themes.

Results

Two major themes emerged from the data with respect to participants' views around the utility of technology as an adjunct to rural face-to-face mental health help-seeking; the themes were *isolation* and *self-determination*. Together they informed participants' help-seeking preferences and interactions with services. Direct quotes from participants are used to demonstrate each theme.

Isolation

Participants' life experiences to date were characterised by strong themes of isolation and disconnection. This history of disconnection was vital in understanding their attitudes toward technology, their help-seeking journeys and preferences more broadly, and thus the types of technologies likely to be beneficial for, and accepted by, young people in the context of face-to-face help-seeking. The value of connection, however, was equally important for their path into and through services.

Family history of mental illness, dysfunction and early personal trauma were common among the participant group, along with a repeated pattern of transient living. Participants frequently discussed the difficulties associated with repeated attempts to establish a foothold within a new rural community. Participants' generally nomadic lifestyles ultimately left them existing on the fringes of their respective communities and they described prior and current experiences of disconnection and isolation which stemmed from their difficulties in developing a friendship network, accessing entertainment and services, and in gaining employment. Where support networks did exist, participants were reliant on a very small group of individuals that included family, partners and health services. Given that the majority of participants had very complex family relationships, the quality of immediate family support was often questionable and sometimes the responsibility of the extended family.

Yeah, I've moved around a lot so haven't really.....this town isn't really like the best for me

because you know, I haven't really made friends with anyone hardly (participant 9)

A predominantly insular and disconnected existence described by participants was compounded by a lack of reliable internet connection and/or financial restrictions with respect to internet access. Two participants living on farms outside of rural centres were unable to access reliable internet which affected the way in which they were able to access mental health support. For example, during one interview an exchange between a participant and their worker revealed that the worker had unknowingly emailed some out-of-session resources and homework to the young person who was unable to access them. In this situation the worker had made assumptions about the client's level of internet access based on the fact that he lived 10 min outside of a major rural centre. The same participant had tried to use an online mental health service for support outside of face-to-face sessions and was unable to as the internet dropped out 5 min after beginning the chat session. In addition, the combination of privacy considerations and restricted internet connection impacted *how* the internet was used. Participants also experienced restricted internet access and ability to use health applications due to limited financial stability and their consequent reliance on mobile phone plan data with their and/or free health apps.

because most of the time I don't have internet with credit (participant 5)

to use the internet on the computer it's kind of like Wi-Fi but we don't have Wi-Fi so it's just like a massive satellite dish that's on top of the roof that picks up like the internet signal.....but like I use my phone because I get like reception in my room but I get very limited so usually I just sit in my room and like go on Facebook or you know message people (participant 7)

Within this context of isolation, personal connections were important for the way in which participants found their way into services. Knowledge of, and access to, services was primarily facilitated through family, but also schools, community members and partners. Participants also voiced the central role of personal connection in facilitation of successful help-seeking once contact with a service had been established; time and again development of a strong personal bond with a mental health worker was held up as the cornerstone of positive health outcomes. Participants also saw a strong relationship between the physical service environment and the quality of the help-seeking experience. Discussions around unwelcoming and non-youth friendly environments highlighted their recurrent feelings of marginalisation and disconnection from services. Additionally,

participants highlighted unwanted interconnections through their numerous examples of inappropriate sharing information by various support workers/organisations, and whilst fear of gossip did not deter participants from seeking help, participants were keenly aware of the risks and impact of it in their rural communities e.g. risks to privacy and confidentiality.

It's, honestly, no wonder that people don't want to go there for help anywhere, because if – you know, the way it is – like, and I'm telling you these rooms are one of the things that will make a person want to leave and not come back....the environment is, indeed, the most important thing (participant 2).

Like gossip is a currency. If people hear things and see things then they'll discuss it with someone and eventually it will spread (participant 8)

Self-determination

The second major theme centred on the different ways in which the young people expressed their desire to make choices about, and have control over, their healthcare. This was despite, for the most part, not being able to make choices in meaningful ways due to systemic (e.g. disjointed service pathways) and structural (e.g. lack of control over the way in which information is shared). Participants' stories and experiences of *the system* reinforced the notion that currently it is set up to serve itself rather than the consumer. Most participants were experienced service users in that they had long and complex histories of accessing services from a young age, from which they had gained many hard won lessons around engaging with the *system*.

trust me, I've been through a few of them. I've been through teams, I've been through private counselling, I've been through – you name it, I've (laughter) probably gone through it (participant 2)

Participants described a mental health system that is difficult to navigate, easy to disengage from and ill-equipped to meet the need of consumers currently battling a mental health condition. Lack of wrap around care and overlap between service boundaries resulted in an inflexible system incapable of meeting the holistic needs of youth.

More not knowing what services are there for what certain things.....It's just you go to one place and then oh no we don't cover that here, you know go to this place (participant 4)

And you have no motivation.....you just, you feel like a zombie, you don't feel like you're there and you don't want to do anything.....you just want to give up.....you wake up in the morning, you think about it and like if you have – like with social anxiety and leaving the house is a bit of an issue you go – all day your brain's just revolved around that one thing, I've got to leave the house, I've got to leave the house, I've got to go out, and that's all your brain thinks about all day..... I'll just call up and say that I'm not coming. And so when I did that a couple of times I'd call up and they'd be like “oh, you know, we'll get them to call you back and book another appointment”. And they never called me back, and I'd call back and they'd say “oh we'll get them to call back”, and they'd never call me back.....then next thing I knew, all of a sudden I didn't have a counsellor anymore, I wasn't seeing anybody, I was just completely wiped off the book, and I slipped through their fingers. (participant 1)

The large majority of participants talked about the re-traumatising experience of repeating their *story* (i.e. their personal and sensitive reason(s) for seeking help) to new service providers despite a clear preference against it. This repetition commonly occurred when young people moved residence, aged out of a service or when their current worker moved onto alternative employment. Bouncing between federal, state and private funded services meant that information sharing between previous and current service providers was extremely limited and thus retelling of stories was expected and required. Several young people discussed attempts to maintain consistency and control by remaining with a current worker despite significant geographic barriers.

You don't want to have to re-live. Like, you've re-lived it once. Re-living it every time brings back the pain you just can't describe it. It's horrible. Like, and the fact that there's more than one person that knows about it is even scarier.....knowing that there's someone that you put your entire life into, to just try and bring you back to life, is – is one thing. And, then to have – you know – two or three new counsellors over a few – over a few years is just – ends up destroying you. Honestly. It destroys you. (participant 2)

In addition, negative experiences of help-seeking generally manifested as personal experiences of perceived loss of control or inability to make decisions around their health.

my experience with [service] was really - I don't know if I'd call it traumatic - but I went there to see a

psychiatrist and I didn't get a choice in the matter. They just sent me to hospital, um so that wasn't great. Didn't go back there (participant 10)

In contrast, participants' positive experiences with services were repeatedly peppered with the term '*comfortable*' with respect to their interactions with individual workers and services more generally. The repeated use of this term spoke to an inherent desire to feel personally in control of, and at ease with, their help-seeking journey. Participants voiced strong preferences around characteristics (e.g. age and gender) and working styles (e.g. non-judgemental, authentic, maintains privacy, mutual trust and respect, client-centred) of mental health professionals. They also demonstrated a strong willingness to disengage when the criteria were not met. The participants believed that fear of the unknown (i.e. not understanding how services function and what to expect from them) and/or judgement (both from peers and the system itself) contributed to their prior (and peers' current) reluctance to engage with services.

He's easy to talk to, he's not one of those like judgy people that I don't like (participant 3)

[with respect to current treatment] there is nothing, I wouldn't change at all because everything that they've done has been run by me first and been okayed by me first and it's all pretty much like, you know, my – they're all my choices and things like that (participant 1)

There are some people out there that will go above and beyond to help out and then there's just other people will just be like nah.....I'm just here to get paid, I don't really give a shit you know (participant 4)

Participants' historical experiences of disconnection shaped their perceptions of appropriate technology-based services and help-seeking. For example, the majority of participants preferred offline modes of mental health help-seeking. Embedded in this preference was the inherent dignity they believed required honouring when disclosing extremely personal thoughts/feelings/experiences to another person. Some participants also noted concerns around the internet as an untrustworthy medium through which to share personal information.

Probably the best thing that I've had is the face-to-face kind of interaction because you actually know who you're talking to and yeah, I don't know, it's just – because if you're ringing up other places you don't know who you're talking to, you don't know what they're doing, if they're actually listening or caring (participant 4)

...I'm a 'people person' and every time people bring up [online service] I always go 'no I'm not doing it'. 'Cause like if I write it down in some website, they'll be a tracker on it or a cookie and that's going to be saved in my file and who knows where else it's going to be (participant 6)

The use of technology as an adjunct to face-to-face care existed on a continuum of no use, some experimentation, through to use of technologies with their current mental health worker. Interestingly, those participants who saw themselves as anti-technology in relation to their help-seeking did not express anti-technology sentiments across the board, with the majority of participants demonstrating a strong preference for use of the internet for socialisation and secondarily for entertainment. E-mental health applications were cited as examples of the way in which young people could take back control of their health and the manner in which they access help. For example, they were used to form a bridge to face-to-face services. Some participants saw value in use of technology to communicate with their worker between sessions, to track their mood and other mental health-related indicators and to assist in better structuring their face-to-face sessions. In contrast, others discussed the value of simple diagrams used by their workers to explain complex psychological and health-related principles and processes. In some cases, young people were very keen to point out reluctance toward technology replacing face-to-face connection with their worker, but that they were open to technologies that, for example, might assist in sharing information between services to avoid story retelling.

There's like been a few issues that like I can't talk to my psychiatrist about, that I'm too like nervous to talk out loud and so I've gone to e-Headspace to talk about it and like they've been really helpful and they've understood that I don't want to like be face-to-face with someone if I'm so nervous about talking about it and I think it's helpful that there are those sites out there like that can help like if you're really having issues and you don't want to talk about it like person-to-person, just online it's really helpful. And it helps people with like anxiety too that don't want to go out and like too scared and anxious to move out of their house (participant 9)

Within this group prior help-seeking was strongly associated with future help-seeking, and many participants noted the difference accessing this help had made to their lives. The disempowering, isolating and complex experience of struggling with, and help-seeking for, a mental health condition, however, led the majority of participants to discuss their desire to help others in a similar position.

The right for all young people to self-determine with respect to their health came through strongly in participants' advocacy for inexperienced consumers. Participants' strong desire to assist these 'inexperienced' young people to access the right information *how*, *when* and *where* they need it spoke volumes with respect to the current help-seeking environment and young people's ability to participate meaningfully within it.

Discussion

The aim of the current study was to investigate rural youth consumers' perspectives of technology-supported face-to-face mental health care. Ten youth from rural South Australia were recruited and two major themes emerged from their semi-structured interviews: *isolation* and *self-determination*. Results indicated that the participants' preferences for and actual use of the internet for (mental) health-related purposes existed on a continuum from no current or future desire to use technologies through to active interest in and current use of technologies as an adjunct to face-to-face care. These results are consistent with prior research that has suggested that while use of technology to support face-to-face services is not considered standard practice by mental health professionals (Blanchard et al., 2012; Montague et al., 2014; Orłowski et al., 2016), some young people consider face-to-face services could be enhanced by and are receptive to technology-based support to their care. The consumer-based perspectives and experiences reported in the current study are in line with a growing body of literature which advocates for the applicability of a mix of on and offline mental health support for some consumers (Blanchard et al. 2012; Montague et al., 2014; Reynolds et al. 2015; Wentzel et al. 2016). As such, the term "blended care" (i.e. a combination of online and offline components coordinated in a face-to-face mental health setting) has now entered the literature (Wentzel et al., 2016), with researchers attempting to define this term and use of technology to support face-to-face care more broadly. Given clinical tools, conceptual models and workforce training are now emerging to support this 'blended' way of working (Abbott et al., 2015; ReachOut.com; Reynolds et al. 2015; Wentzel et al., 2016) this change to service delivery must be balanced by a nuanced understanding of the consumer cohort currently accessing face-to-face mental health services.

It was indicated that, in general, the personal and geographical isolation felt by most participants shaped their help-seeking preferences and experiences, which manifested in a strong need for personal connection with a mental health worker. A participant's desire for personal connection in help-seeking - characterised by acceptance,

respect, trust, lack of judgement and authenticity - has been reported elsewhere in the literature (Boyd et al. 2007; Salamone-Violi et al. 2015), and as such, these findings suggest learnings for the research, service delivery and policy-based communities with respect to design and implementation of technologies. Information communication technologies that may appear to threaten the personal connection and support that are currently available through services may not be supported by, and/or beneficial to, this group of young people. In contrast, applications that enhance or promote and don't seek to replace the desired personal connection are more likely to be better received and utilised by youth mental health consumers. The range of perspectives participants demonstrated with respect to the value of adjunct clinical technologies are in line with recent evidence on the level of tailoring required for successful technology design (Ranney et al. 2015). In addition, the physical and/or material restrictions around internet access highlighted in the results reinforce the idea that this a group of young people who, at this point, are reliant on a predominantly face-to-face mental health service model. The need for design of inclusive technologies that recognise and accommodate the needs of young people who, along with their mental health (and often comorbid physical health) struggles, are socially and geographically disadvantaged is therefore emphasised. Much can be learnt from the design and implementation of technologies to meet mental health need and develop capacity in underprivileged and war-torn countries such as Afghanistan (Gillis 2015). Low cost and limited internet dependent alternatives should be a focus for future research and design, for example teleconsultations that allow for live and 'store and forward' modes to accommodate those with limited or unreliable internet access (Gillis 2015).

The self-determination theme present in the data has significant implications for the ways in which youth consumers are involved in service planning and delivery. The concept of self-determination is tied strongly to the mental health recovery literature, with its importance in facilitating (and indeed hindering) recovery—a multi-dimensional term encompassing a range of outcomes—well-documented (Anthony 1993). As such, the current participants' experience of systemic disempowerment and lack of self-determination are, unfortunately, not uncommon (Anthony 1993). With the existence of inspiring examples of youth-based participatory research, which demonstrate that it is possible to give meaningful voice to those with lived-experience of mental illness (Lincoln et al. 2015), it no longer seems justifiable that these perspectives should not be honoured and included in technology design and implementation processes. These participatory practices that stand to create greater opportunities for consumer self-determination may also benefit the design process. If

designed sensitively and inclusively, technology-based additions to care could offer welcome opportunities for young people to participate more meaningfully in their care. For example, flexibility and shared decision-making, two attributes often linked to technology-based additions to care, have been linked to improved patient satisfaction and overall health outcomes (Clever et al. 2006; Swanson et al. 2007).

The current study has a number of limitations. Perspectives were sought from two different rural regions, and whilst this design allowed for in-depth data collection and analysis, the results should be understood in this context and as such may not be representative of the experiences of different regions. Additionally, it is also important to note that nine of the ten participants reside in inner rural regions and thus views and experiences of outer regional and more remote communities were not represented in this study. Whilst the study did sample consumers with a range of mental health conditions, the large majority identified as dealing with depression and anxiety based concerns. These young people were recruited from two mental health services, the extent of issues raised in the data, however, suggests that any potential bias arising from sampling young people with a more positive relationship with their worker was minimal. Finally, the participants were actively engaged in face-to-face mental health services and as such the results may not generalise to all youth in need of mental health services, particularly those who have never accessed, or have disengaged with, face-to-face services.

The results of this study highlight consumers' desire for self-determination around their health and help-seeking within a current service environment that systematically subverts it. The results also reveal important reasons why young people who use offline mental health services may be averse to technological additions to their care. By and large, this was a group of young people with disadvantaged, traumatic backgrounds and corresponding long and complex histories of help-seeking. They have systematic experiences of isolation, and often present for help with complex problems, which shape their need for face-to-face care. In addition, limited financial and infrastructural resourcing make it more difficult to access help online. That said, some young people self-identify as interested in engaging with technology-supported models of care. Understanding and actively seeking out these views in design and implementation of technologies is vital for design of useful and usable technologies and, more importantly, is in line with the current shift toward more consumer-focussed and inclusive service design and delivery.

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Compliance with Ethical Standards

Conflict of Interest No conflict of interest declared.

Research Involving Human Participants and/or Animals All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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