e-MENTAL HEALTH SERVICES IN AUSTRALIA 2014: CURRENT AND FUTURE

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EXECUTIVE SUMMARY

This report has been prepared by the e-Mental Health Alliance representing the core group of organisations listed above, who are currently providing highly effective and cost efficient e-Mental Health (eMH) services directly to the Australian population.

There is no doubt that technology is changing the way in which healthcare is accessed, received and delivered, and that the role of eMH will continue to grow. We need to build on the foundations established by government (starting in the Howard years) and industry in this country, to take advantage of rapidly changing technology and patterns of health and social care.

The Purpose of the report is to provide the Commonwealth Government and National Mental Health Commission with an up-to-date picture of eMH services in Australia and to propose achievable and scalable solutions to unlock the even greater potential of eMH for the community. The Alliance’s recommendations show how these services can:

- be sustainable and continue to assist Australians over the long term;
- deliver efficacious, non-stigmatising and immediate support to even more individuals and families;
- lower the currently increasing health costs to government;
- be funded as a continuing component of the Australian mental health system, rather than as isolated experiments or innovation projects; and
- for the first time be linked together as a sector and integrated into a fully functional and more efficient mental health system of stepped care that complements public and private practice.

To achieve this vision, it is recommended that:

1. Australian eMH services are linked together in a “chain or ecosystem of care” with the facility for cross referral where indicated, and they are also linked into the health system at multiple points to enhance referral through several routes:
   a) directly from individuals or via community-based organisations (e.g. schools, workplaces)
   b) directly from telephone help and crisis lines and online services as referrals of through creating service pathways
   c) via primary care (e.g. general practice); and
   d) via referral by public and private specialist mental health services (e.g. allied health professionals and NGOs).

All eMH services will be linked via an integrated software platform, such as the Synergy Project, which is being used to link youth mental health services. This will facilitate data linkage, referrals and inter-operability across the “chain or ecosystem of care”.
2. All Commonwealth funded mental health services are required to educate and make the public aware of eMH services as an option available to them using consistent national messages. Together with direct-to-the-public awareness raising initiatives, they will address the limited levels of eMH awareness in the community, particularly in relation to the effectiveness and accessibility of eMH services and empower consumers and families to seek them out or ask for a referral.

3. Training and education programmes for health professionals (such as eMHPPrac) are continued in order to:
   a) build awareness of existing eMH health programmes and services;
   b) develop systems that allow for successful incorporation of referral and follow-up into routine face-to-face practice; and
   c) coordinate with organisations and professionals in community organisations (e.g. school counsellors), in a staged approach to expansion.

Training and education programmes for non-health professionals are introduced to build awareness about self-directed eMH programmes and establish systems for client referral to those programmes.

4. A sustainable funding model is established which:
   a) includes incentives to General Practitioners (GPs) and eligible allied health professionals (e.g. psychologists) to refer patients to low cost eMH services;
   b) identifies and supports areas of unmet need, and funds subsequent innovation, to investigate new models of service delivery;
   c) supports the generation and reporting of outcome data, quality control and advice in the form of shared standards, safety protocols and accreditation, while still allowing for the development of new services;
   d) incorporates and supports the ongoing nature of programme enhancements and technical upgrades; and
   e) takes account of the ethical issues that arise with changes in technology, mental health online delivery, and mental health research.

5. Time-limited governance arrangements are established to facilitate the implementation of Recommendations 1-4, including the re-establishment of the eMental Health Advisory Committee.
WHAT IS e-MENTAL HEALTH?

e-Mental Health (eMH) is the delivery of services targeting common mental health problems through online and mobile phone interactive websites, apps, sensor-based monitoring devices and computers. The term also extends to telephone crisis lines and online crisis support services. eMH services are delivered in real-time through multiple settings, including the home, the workplace, schools, and through clinicians’ workplaces.

Some services offer fully automated self-help programmes, while others involve guidance from clinicians, crisis workers, teachers, administrators or peers.

The term e-mental health (eMH) in this paper does not refer to the Government’s work around the Personally Controlled Electronic Health Record.

Five types of eMH service or programmes can be distinguished: (see Table 1 for details about individual services/programmes, along with their URLs)

1) **Health promotion, wellness promotion and psycho-education**
   Examples of these programmes include BluePages, beyondblue, ReachOut.com, mindhealthconnect, KidsMatter, MindMatters, HeadsUp, Man Therapy and Beacon.

2) **Prevention and early intervention**
   Examples of these programmes include BiteBack, Kids Helpline, BraveOnline, Climate Schools, beyondblue’s Support Service, eCouch and MoodGYM.

3) **Crisis intervention and suicide prevention**
   Examples of these programmes include Lifeline, Healthy Thinking and ibobbly

4) **Treatment**
   Examples of these programmes include myCompass, eCouch, MoodGYM, This Way Up, Mental Health Online, SHADE, eheadspace and others.

5) **Recovery and mutual/peer support**
   Examples of these programmes include BlueBoard, an online internet support group for people with depression, or telephone support lines staffed by mental health consumers.

Overall, eMH services in Australia make up an efficient, effective sector, complementary to conventional face-to-face delivery of mental health services. Consumers increasingly are showing their willingness to utilise services delivered through technological means, which supports the importance of linking these services together as a sector and regarding them as components of a fully functional and integrated mental health system.

WHO ARE WE?
The e-Mental Health Alliance authored the “*e-Mental Health 2020 Vision and Strategy for Australia*” in 2009 (1), which outlined the need for efficient eMH service delivery in Australia. This provided the basis for the Government’s “*e-Mental Health Strategy for Australia*” (2), released in 2012.
Today, five years on from our initial 2009 “e-Mental Health 2020 Vision and Strategy for Australia”, we review achievements in eMH in Australia, assess the outstanding needs, and propose solutions, in particular the need for a fully integrated and comprehensive eMH care sector that is funded as a continuing component of the Australian mental health system, rather than as isolated experiments or innovation projects.

The present document focuses on services currently provided to the community. However, the Alliance aims to include other key players and innovations in the eMH space as new services develop. This includes the broad range of eMH developments currently underway at the Young and Well CRC (e.g. Online Well-Being Centre, Project Synergy, Recharge mobile phone app), beyondblue (e.g. national rollout of redeveloped MindMatters, HeadsUP and New Access) and professional clinic developments at the University of Sydney (e.g. eMH clinical staging) and Orygen Health.

**e-MENTAL HEALTH IN AUSTRALIA TODAY**

Australia is a world leader in the research, development and delivery of eMH solutions. Table 1 lists eMH promotion, psycho-education, prevention, early intervention, crisis intervention, suicide prevention, treatment, and recovery services provided by Alliance partners. The Department of Health’s Telephone Counselling, Self Help and Web-based Support Programme (Teleweb) supports a number of these services, including the key portal site – mindhealthconnect – which provides links to e-mental health programmes and services, a virtual clinic – MindSpot – and the e-Mental Health in Practice (eMHPrac) training programme which promotes the use of eMH services in primary care settings, plus a range of specific promotional or therapeutic interventions. The Department of Health’s Taking Action to Tackle Suicide (TATS) funding funds a number of other services.

Australia’s eMH services are distinguished by the following features:

- They are based on “gold standard” evidence.
- They lower health costs by limiting the amount of real time involvement of health professionals in the delivery of an ‘episode of care’.
- They facilitate help seeking behaviours by people with mental health and suicide issues, and assist those who may not seek traditional health services.
- They support the creation of pathways between eMH services and conventional services including primary health care.
- They can be easily and cheaply scaled up, and disseminated widely.

**STRENGTHS OF THE e-MENTAL HEALTH SECTOR**

1. **High usage**

Australian eMH services cater to a range of audiences with different needs and are accessed at high rates, as per Table 1. eMH services are popular, accessible, and acceptable, and appeal to young people, who tend not to access traditional health services (3). Australians report being willing to use eMH services (4, 5) and these services are viewed as acceptable
as seeing a health professional (6). They are also popular owing to their low or no cost, privacy, anonymity, convenience, and accessibility at any time of day.

eMH services adhere to clinical risk management and security standards. Teleweb-funded services have regular IT security audits and penetration tests which are conducted by independent IT security auditors, sites are hosted by providers with high ISO accreditation, and there is strict adherence to IT governance procedures. With respect to clinical risk, consumers are routinely screened for symptom severity before registration and during programme use, inbuilt alert mechanisms trigger service responses, with users referred or offered face-to-face assistance.

2. Clinical Effectiveness
The clinical effectiveness of Australian eMH services is now well-established in all five domains of eMH. A detailed overview of the high levels of clinical effectiveness of Australian eMH services is provided in Table 3. In brief:

a) Health promotion, wellness promotion and psycho-education
Health promotion and psycho-education programmes (e.g. BluePages) are effective in reducing symptoms (7, 8), while providing consumers with social connections in a safe, non-stigmatising environment. Well implemented programmes providing information and training in community settings such as schools (e.g. KidsMatter) are associated with improvements in academic performance (9), symptoms and behaviours (10). They can also facilitate referral to other services, particularly for hard to reach groups such as men (e.g. Man Therapy) (11) and distressed young people who have not previously accessed health services (e.g. ReachOut.com) (12).

b) Prevention and early intervention
Contacts with Kids Helpline regarding mental health, emotional wellbeing, suicide, and self-harm have been increasing, with young people reporting that the service provides strategies enabling them to better cope with their concerns (13). beyondblue’s support service which offers brief telephone, email and web chat counselling and referrals have also been found to reduce distress, connect people to treatment and increase motivation to act (14). Positive psychology websites targeting young people (e.g. BiteBack) reduce depression and stress, while improving well-being (15). Internet-based prevention in schools is effective for substance use (e.g. Climate Schools) (16), and depression and anxiety (e.g. MoodGYM) (17), while early intervention with children can reduce anxiety (e.g. BRAVE), with gains persisting for up to 12 months (18).

c) Crisis intervention and suicide prevention
One third of callers to Lifeline telephone crisis line and almost half of visitors to Lifeline online crisis support chat service report feeling suicidal at the time of contact. Visitors to Lifeline’s online crisis support chat service report decreased distress and sense of aloneness and increased confidence to cope with problems (19). Furthermore, 50% of Lifeline visitors utilised service referrals to access other mental health services including many eMH services. Likewise, there is a measurable reduction in suicidality during a service session for callers to Kids Helpline (20).
Preliminary data suggest that web-based interventions targeting distress, suicide ideation and impulsivity, such as Black Dog’s Healthy Thinking and ibobbly, can reduce suicidal thinking (21).

**d) Treatment (e-therapies)**
Treatment services (e.g. e-couch, myCompass, ThisWayUP) targeting clinical and sub-clinical populations using online cognitive behaviour therapy programmes are effective in reducing symptoms in depressive and anxiety disorders (22-24), with effects comparable to face-to-face treatments (23). The number-needed-to-treat is estimated to be 2.18 (23). The effectiveness of these CBT programmes translates to “real world conditions” (25). They improve work and social functioning (26), they are effective with comorbid alcohol or substance use problems (e.g. SHADE) (27), and integrate with primary care services (28), and psychological treatment services (29). Online interpersonal therapy (IPT) can also reduce symptoms (30).

**e) Mutual support and recovery services**
There is evidence that facilitated participation in an online support group (e.g. BlueBoard) (31) can reduce symptoms of depression. Peer support is a promising but under-researched area.

Although many of the existing eMH services were developed for people with mild-moderate symptoms, eMH increasingly is being found to be useful for people with more severe symptoms.

**3. Cost efficiency**

International research (including some Australian eMH programmes) shows that delivery of eMH is both cost-effective and cheaper to provide than care as usual (24), particularly for depressive and anxiety disorders. There is significant return on investment from eMH services, which leads to improvements in both cost-benefit ratios and sustainability of care (32). For example, a social return on investment study of Lifeline Online Crisis Support Chat service estimated a return of $8.40 for every $1 dollar invested in this service (19).

Figure 1 illustrates a preliminary estimation of costs related to delivering eMH treatments in comparison with the cost of providing other mental health services in Australia. For example, a cost-utility analysis of clinical trial data from the myCompass programme for depression and anxiety shows that the programme can be delivered in a cost-effective manner, with a cost per QALY gain of $3508 (unpublished data). This is approximately one fifth the cost of treatment with antidepressants and a tenth the cost of recommended treatment with a psychologist to achieve the same QALY gain.

Recent estimates in Australia have shown that high psychological distress increases employee absenteeism and decreases work productivity up to 20.9%, translating to an annual loss of $5.9 billion (33). Cost-effective treatment services can reduce costs associated with lost productivity (34).
**Figure 1: Stepped care model of eMH service provision and associated costs**

*General anxiety diagnostic criteria assessed by MINI
Change in depression severity measured by PHQ-9 or BDI-II
Psychological distress/disability assessed by K10 and WHOQoL-4L
Measure of distress completed at every lesson; automated clinician alerts for rising distress scores*
The cost-effectiveness and lower overall expenditures of eMH in relation to other services arise from:

- The low marginal costs of providing eMH services to individuals
- Volume savings as the number of patients treated increases
- Significant clinical improvement despite reduced, minimal or no therapist support, reducing per patient costs while maintaining efficacy (35)
- Reduced referrals to secondary mental health services and shortened waiting lists for face-to-face therapy in primary and secondary care (36)
- Use of lower cost non-clinical services for information, crisis support and peer support purposes, supplementing the higher cost services as appropriate
- Additional benefits arising from immediate and unrestricted access to treatment, easier disclosure of sensitive information, removal of the need to travel to a therapist, and availability of eMH programmes for booster or revision sessions to prevent relapse.

Dissemination of eMH services can also potentially reduce demand on primary and secondary services and lessen medication use and chronicity, leading to further reductions in the individual and societal cost burden. Furthermore, recent overseas research into online preventive interventions reported that they have the potential to be cheaper to implement than some treatment services, even before taking into account lost productivity due to illness (37). Research indicates that the successful prevention of mental illness has the largest impact on labour force participation of any condition (38).

**CHALLENGES TO THE e-MENTAL HEALTH SECTOR**

Although they are acceptable, effective and cost effective, eMH services face challenges. Below we outline three major challenges and their potential solutions. A table showing the challenges and the effects of investment in our strategic response to such challenges is included in the appendix (Table 3).

1. **Awareness of eMH services requires attention**

During a given 12 month period in Australia, 3.2 million people experience a mental disorder such as anxiety, depression, substance abuse (39). However, in 2007, only 34.9% of people with a mental disorder accessed services from a mental health professional (39), with this figure rising to 45% in 2010 through the Better Access Initiative (2). Increasing awareness of eMH services by both the public and health professionals would increase the number of those with a disorder seeking and receiving help, at a significantly reduced cost than increasing traditional face-to-face services.

Importantly, the existing high levels of community awareness of national crisis lines and online services, such as Lifeline, could be better harnessed to facilitate the promotion of eMH services.
**Solution**: Improve community and professional awareness about the existence and effectiveness of eMH services and programmes and systematically address barriers to use. Establish protocols for referral to eMH services via crisis lines and online services to improve awareness and use of eMH services.

2. **eMH services have a place in the health system, but their potential has not been realised and there has been fragmentation in funding and therefore implementation.**

There is a need to provide access points in multiple (health and non-health) settings, to integrate across providers and with face-to-face health systems, in order to offer tailored responses.

Funding shortages and resource scarcities in the eMH sector have resulted in fragmentation and competition, with consequences for service quality, sustainability and treatment fidelity. The number of services, apps, and websites has produced an increasingly non-integrated system and there are likely to be services with low security and poor adherence to ethical protocols.

**Solution**: The largest gap in mental health service delivery in Australia is for people with mild-moderate mental health disorders (see Table 4). Considering current numbers of people living with mental disorders, based on diagnosis and severity, we estimate that approximately 600 000 people experiencing a mild-to-moderate mental illness are potentially eligible for access to an eMH intervention as a first line of treatment, where interventions are acceptable to the individual.

International estimates of future mental health expenditure indicate that the number of cases will increase by 14.2% over the coming 20 year period, service costs will increase by 45% (40), and total cumulative costs associated with mental illness are expected to increase over six-fold (41). While mental disorders make a relatively small contribution to mortality, they are a major disabling condition and will account for 24.2% of all years lost to disease (42).

**Table 4: Gaps in mental health treatment access, by symptom severity**

<table>
<thead>
<tr>
<th>Rate of people with a mental disorder accessing treatment (by severity) (43)</th>
<th>Access to treatment as a % of the population living with a mental disorder</th>
<th>N of people living with mental disorders potentially eligible for eMH (44)</th>
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<tbody>
<tr>
<td>Severity</td>
<td>Current</td>
<td>Target</td>
</tr>
<tr>
<td>Mild</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Moderate</td>
<td>59%</td>
<td>80%</td>
</tr>
<tr>
<td>Severe</td>
<td>93%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>46%</td>
<td>65%</td>
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</table>

**Note**: This table estimates the number of Australian people living with a mental disorder (based on 12 month prevalence data) who would potentially be eligible for eMH services as part of a stepped care intervention. These estimates are derived from epidemiological survey data, combined with administrative data on people receiving mental health care from the Commonwealth and State and Territories. Targets are based on expert opinion (44).
Thus, there is substantial economic gain to be made from optimising the prevention and treatment of mental ill health. eMH has the potential to attenuate the impact on resources and costs associated with increased population treatment rates, whilst maintaining effectiveness by leveraging existing technologies.

We propose that eMH is integrated within the existing health care system using a **stepped care model**, with eMH services routinely offered to people with mild-moderate depression and anxiety as a first step (Figure 1), in keeping with the stepped-care framework identified in international guidelines as the method by which treatments for depression should be delivered (45). Access to these services could be direct and through GPs and other face-to-face providers, to ensure that more Australians can be reached, particularly young people in schools and universities (46), those not in contact with health care services (e.g. different cultural groups)(47), those who do not want to access support through traditional mental health services (e.g. men and young people) and people in the workplace.

In addition, eMH providers need to be linked in a “chain or ecosystem of care” with governance arrangements that cover referral in and out of each of each other’s services, depending on need and severity (Figure 2).

The advantages of offering eMH treatments as a first step in a stepped care model arise because:

- Minimal interventions can provide ‘significant health gain’ equivalent to that of traditional psychological therapies, at least for a proportion of patients (equivalence).
- Using minimal interventions allows current healthcare resources to be used more efficiently (technical efficiency).
- Minimal interventions and the stepped care approach are acceptable to patients and professionals (acceptability).

Figure 1 illustrates how people can either commence a low impact, low cost eMH programme following a referral pathway, or directly engage with an eMH service provider. It also shows how treatment is escalated depending on the response of the individual. The costs of each level of intervention are estimated from our analysis of baseline costs of providing an eMH programme (based on the recent cost effectiveness analysis of myCompass). Costs to the provider for each additional intervention (e.g. GP visit, medication) are based on the current MBS schedule of fees for each professional service, and costs to the patient are based on fee schedules from the Australian Psychological Society. Costs for one course of antidepressant drugs are taken from the Pharmaceutical Benefits Scheme website.

Emphasis is on continuity of care, continuity of employment/income, and consequent decreased morbidity for patients.
3. eMH services need to better incorporate prevention and recovery services, address low adherence and incorporate user input into design. Findings are mixed about the amount and type of support that is optimal to maximise outcomes and there is a need to continually update service platforms to remain compatible with new technologies.

**Solution:** eMH services will improve via better incorporation of consumer preferences during the design process, identification and removal of barriers to adherence, consistent and ongoing evaluation of newer support models, use of new technologies (e.g. sensor based measures), and customisation for a greater range of cultural groups. Funding to undertake enhancements and extensions of the programmes is an essential component to overcoming these sectoral challenges.

**RECOMMENDATIONS**

Our vision is for Australia to have a high quality eMH care system, delivering care through a connected eMH ecosystem, which links seamlessly with the broader Australian healthcare system and expanding beyond it. Figure 2 below illustrates this vision by showing interactive referral pathways that encompass multiple points of entry to an integrated model of service delivery.

To achieve this vision, it is recommended that:

1. Australian eMH services are linked together in a “chain or ecosystem of care” with the facility for cross referral where indicated, and they are also linked into the health system at multiple points to enhance referral through several routes:
   a) directly from individuals or via community-based organisations (e.g. schools, workplaces)
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   c) via primary care (e.g. general practice); and
   d) via referral by public and private specialist mental health services (e.g. allied health professionals and NGOs).

   All eMH services will be linked via an integrated software platform, such as the Synergy Project, which is being used to link youth mental health services. This will facilitate data linkage, referrals and inter-operability across the “chain or ecosystem of care”.

2. All Commonwealth funded mental health services are required to educate and make the public aware of eMH services as an option available to them using consistent national messages. Together with direct-to-the-public awareness raising initiatives, they will address the limited levels of eMH awareness in the community, particularly in relation to the effectiveness and accessibility of eMH services and empower consumers and families to seek them out or ask for a referral.

3. Training and education programmes for health professionals (such as eMHPrac) are continued in order to:
a) build awareness of existing eMH health programmes and services;
b) develop systems that allow for successful incorporation of referral and follow-up into routine face-to-face practice; and
c) coordinate with organisations and professionals in community organisations (e.g. school counsellors), in a staged approach to expansion.

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4. A sustainable funding model is established which:
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   e) takes account of the ethical issues that arise with changes in technology, mental health online delivery, and mental health research.

5. Time-limited governance arrangements are established to facilitate the implementation of Recommendations 1-4, including the re-establishment of the eMental Health Advisory Committee.

The benefits to Australian mental health from these recommendations can be seen in Table 3 (Appendix).
Figure 2: Proposed innovations to eMH service delivery
# APPENDIX

## Table 1 – AUSTRALIAN eMH SERVICES and USAGE

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<thead>
<tr>
<th>SERVICE ORGANISATION</th>
<th>KEY AUDIENCE AND SERVICES PROVIDED</th>
<th>USAGE</th>
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<tr>
<td><strong>HEALTH PROMOTION, WELLNESS PROMOTION AND PSYCHO-EDUCATION</strong></td>
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| Beacon [https://beacon.anu.edu.au/](https://beacon.anu.edu.au/) | • Key audience: consumers and health practitioners  
• Provides guidance on the content, quality and availability of –ehealth applications including online tools, mobile apps and online support groups  
• Consumer and researcher ratings are provided | • 9,810 unique visitors per month, on average.  
• No registration required.  
• 76,503 pages accessed per month, on average. |
• Communication and education through provision of comprehensive information on depression and anxiety including recognising symptoms  
• Promotes early action and recovery | • 208,000 visitors per month, on average  
• No registrations required |
| Black Dog Institute [http://www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au) | • Key audience: all Australians  
• Information, education, psycho-education focused on depression, bipolar disorder and anxiety disorders  
• Screening tools, referrals to eMH programs and clinicians  
• Contact point for community education programs | • 121,332 unique visitors per month, on average  
• 276,115 unique page views per month, on average  
• No registrations required  
• 1,823,656 annual visitors |
| BluePages [http://bluepages.anu.edu.au](http://bluepages.anu.edu.au) | • Key audience: people with depression  
• Evidence based information about depression  
• Automated screening tools for depression and anxiety  
• Information about the experience, symptoms and diagnosis of depression  
• Information about psychological, medical and alternative/lifestyle treatments for depression | • 9,701 unique visitors per month, on average  
• No registrations required  
• 229,638 pages accessed per month, on average |
• Online resource providing information about mental health and the workplace. The website offers simple tools e.g. an action plan for business), practical advice, information and resources to take action | • 87,000 visits to the website in first six weeks  
• Since June launch 4,700 businesses and individuals have registered for further information on mentally healthy workplaces |
### HEALTH PROMOTION, WELLNESS PROMOTION AND PSYCHO-EDUCATION

#### (continued from previous page)

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| **KidsMatter**
National Primary Schools Mental Health Initiative  
- Objective: strengthen capacity of primary school communities to support children's social and emotional development and to respond effectively to child mental health issues  
- Provides online resources and training, links to evidenced-based programs and services | - 2,000+ school communities currently participating |
| **Man Therapy**  
[www.mantherapy.org.au](http://www.mantherapy.org.au) | - Key Audience: men - 30-54 years  
- Practical information for men dealing with stress, anxiety and depression  
- Online screening tool and links to programs and services | - 691,302 website visits  
- 152,000 completions of Man Quiz (K10)  
- Has reached 41% of men aged 30-54 years (approx 1.5 million) |
| **mindhealthconnect**  
Healthdirect Australia  
[www.mindhealthconnect.org.au](http://www.mindhealthconnect.org.au) | - Key audience: National e-mental health website for the public and health professionals  
- Brings together Australia's leading mental health providers in one place  
- Find relevant mental health and wellbeing information, online programmes, services, tools, news, helplines  
- Operated by Healthdirect Australia, on behalf of the Australian Federal Government | - Data not available at present |
| **MindMatters**
National Secondary Schools Mental Health Initiative | - Key Audience: school leadership, teachers and parents  
- Objective: strengthen capacity of secondary school communities to support student resilience and to respond effectively to youth mental health issues  
- Provides online resources and training, links to evidenced-based programs and services  
- Online forums | - 1500 schools to be recruited through to mid-2016 |
| **ReachOut.com**  
[www.reachout.com](http://www.reachout.com) | - Key audience: young people aged 14-25  
- Non-clinical mental health promotion and early intervention service  
- Information, self-help referral, peer support via online forum  
- Anonymous, available 24/7, accessible on computers/mobile/tablet  
- Referral pathways (41% of distressed young visitors to the site said they would be more likely to seek additional help after using R/O) | - On average 170,000 unique visitors per month, on average  
- No registration required  
- 1.7 million annual visits on average |
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<td><strong>PREVENTION AND EARLY INTERVENTION</strong></td>
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| beyondblue support service | - Key audience: people experiencing distress  
- Telephone (24 hr – 1300 224636), email and web chat counselling with trained mental health professional  
- Provides brief interventions/support and referral | - 8,583 contacts per month, on average during the first full year of operation – 2013/14 (telephone, email or web chat) |
| BiteBack | - Key audience: 12-18 year olds  
- Prevention  
- Services: well-being and resilience building | - Current pilot project with 2 schools, available to research populations only |
| Brave Online | - Key audience: Children and adolescents with risk factors (e.g. temperament) or early signs of anxiety  
- Self-help, therapist assisted, or supported by school staff  
- Full-automated | - 3,400 unique visits per month, on average  
- 75 registrations per month, on average  
- 2,646 registered users since 2011 |
| Climate Schools | - Key audience: secondary school students  
- Health education courses available via website, with teachers delivering additional activities to reinforce online lessons: alcohol education, alcohol and cannabis use, psychostimulant and cannabis education | - 313 unique visitors per month, on average  
- 3,716 page views per month, on average  
- 90 schools currently registered and using the programme |
| e-couch | - Key audience: adults aged 20-70 years  
- Information and automated self-help program that includes a literacy component and online tools for prevention and treatment of depression, generalised anxiety disorder and social phobia  
- Two additional tailored streams for bereavement and loss, and divorce and separation | - 1,000 community registrations per month, on average  
- 7,256 unique visitors per month, on average  
- 393,038 pages accessed per month, on average |
| Kids Helpline | - Key audience: children and young people aged between 5 and 25 years  
- Kids Helpline Counselling Services – provides free, private and confidential counselling and information/referral for children and young people aged under 26 years across Australia via phone, web and email  
- www.kidshelp.com.au – provides a range of information and self-help resources for children, young people and adult carers | - 18,952 counselling contacts per month, on average (15,460 via phone; 1,978 via email; 1,514 via web)  
- 44,531 unique visitors to Kids Helpline website per month, on average  
- 28,105 webpage views of Hot Topics covering information and coping strategies for a variety of problems (14,526 page views of “teens” Hot Topics; 10,666 page views of “grownups” Hot Topics; 2,913 page views of “kids” Hot Topics)  
- 10,337 webpage views of self-submitted stories of young people’s problems and their experiences contacting Kids Helpline  
- 480 connections with Search for a Service function  
- No registrations required |
### Prevention and Early Intervention (continued from previous page)

<table>
<thead>
<tr>
<th>SERVICE ORGANISATION</th>
<th>KEY AUDIENCE AND SERVICES PROVIDED</th>
<th>USAGE</th>
</tr>
</thead>
</table>
| MoodGYM [http://moodgym.anu.edu.au](http://moodgym.anu.edu.au) | • Key audience: people at risk of developing a common mental health problem or who are experiencing depression or anxiety symptoms  
• Automated, self-help CBT for depression with 5 modules and 29 online exercises | • 9,400 community registrations per month, on average  
• Over 800,000 registrations  
• 36,834 unique visitors per month, on average  
• 3,154,840 pages accessed per month, on average |
• Trained coaches provide individually tailored low intensity CBT to clients incorporating e-mental health programs/supports | • Currently only available to research participants at three pilot sites located in SA, ACT and NSW |

### Crisis Intervention and Suicide Prevention

<table>
<thead>
<tr>
<th>SERVICE ORGANISATION</th>
<th>KEY AUDIENCE AND SERVICES PROVIDED</th>
<th>USAGE</th>
</tr>
</thead>
</table>
| Lifeline [https://www.lifeline.org.au/](https://www.lifeline.org.au/) | • Key audience: Australians experiencing a crisis  
• Lifeline 13 11 14 – national telephone helpline  
• Lifeline Online Crisis Support Chat Service – one on one confidential chat service  
• Lifeline Suicide Hot Spot crisis line – specialist telephone helpline  
• Lifeline Online ‘Get Help’ – self-help resources at lifeline.org.au | • Lifeline 13 11 14: average 60,000+ calls per month, on average  
• Online Crisis Support Chat: average 2,500 contacts per month  
• Suicide Hot Spot Crisis Line: average 1,500 calls per month  
• No registrations required  
• lifeline.org.au – on average 58,000+ unique visitors per month  
• Online ‘Get Help’ resources – 8,000 unique page views per month  
• Referrals to other services – 2/3 of callers and chat visitors receive referral to other services |
| iBobby Black Dog Institute | • Key audience: Aboriginal and Torres Strait Islander peoples aged 16-35 years.  
• Treatment for suicidal ideation based on acceptance and commitment therapy  
• Currently undergoing upgrades and improvements | • Currently only available to research participants in pilot study in the Kimberley, WA  
• Public release date TBA |
<table>
<thead>
<tr>
<th>SERVICE ORGANISATION</th>
<th>KEY AUDIENCE AND SERVICES PROVIDED</th>
<th>USAGE</th>
</tr>
</thead>
</table>
| Bravely Online       | Key audience: children and adolescents with anxiety disorders  
                      | Fully automated online intervention for anxiety in youth, delivered via computer, mobile phone or tablet  
                      | Minimal therapist assistance  
                      | Cognitive behavioural therapy, problem solving therapy, cognitive challenging, exposure  
                      | delivered via 10 interactive modules for young people (plus 2 booster sessions)  
                      | 6 interactive modules for parents (plus booster sessions)  
                      | Separate programmes for children vs adolescents  
                      | Additional programme with specific sessions for social phobia  
                      | To date, the clinician supported version of the programme is only accessible via research group in Australia  
                      | Being used with clinically anxious children post the Christchurch earthquake |
| e-couch              | Key audience: adults aged 20-70 years  
                      | Information and automated self-help program that includes a literacy component and online tools for treatment of depression, generalised anxiety disorder and social phobia  
                      | Two additional tailored streams for bereavement and loss, and divorce and separation  
                      | 1,000 community registrations per month, on average  
                      | 7,256 unique visitors per month, on average  
                      | 393,038 pages accessed per month, on average |
| OnTrack, QUT         | Key audience: Australians with a health problem  
                      | Information services for a range of health conditions  
                      | Self-rated quizzes on drinking, mood and relationships with feedback supplied  
                      | Interactive online programmes for depression, alcohol & depression, family & friends, psychosis, flood and storm recovery, diabetes  
                      | iPhone/iPad apps for meditation  
                      | iPad app, Stay Strong, which is used by workers in Indigenous health settings  
                      | 1,400+ unique visitors per month, on average  
                      | No registrations required for screening  
                      | 916 registrations for web programmes  
                      | 63,526 page views since 2009 |
| Mental Health Online | Key audience: adults aged 18 years or more  
                      | Information and self-guided assessment for 21 disorders  
                      | Guided and unguided self-help online CBT for generalised anxiety disorder, obsessive compulsive disorder, panic disorder, depression, insomnia, PTSD and social anxiety disorder, as well as a transdiagnostic programme (depression and anxiety) for same-sex attracted young people  
                      | Tailored integrated resources for people with comorbid problems  
                      | Availability of therapist support via e-mail, text chat, voice-over internet, video chat and within a VR space  
                      | Additional programmes offered through participation in research (e.g. depression, insomnia, compulsive hoarding)  
                      | eTherapist Online training and placement opportunities  
                      | 1,380 unique visitors per month, on average  
                      | 625 registrations per month, on average  
                      | 22,098 page views per month, on average |
### Service Organisation: Key Audience and Services Provided

#### Treatment and E-therapy Services (continued from previous page)

<table>
<thead>
<tr>
<th>Service Organisation</th>
<th>Key Audience and Services Provided</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MoodGym</strong>&lt;br&gt;<a href="http://moodgym.anu.edu.au">http://moodgym.anu.edu.au</a></td>
<td>- Key audience: people with depression or anxiety symptoms. Designed for young people but used by all ages.&lt;br&gt;- Automated, self-help CBT for depression with 5 modules and 29 online exercises</td>
<td>- 9,400 community registrations per month, on average&lt;br&gt;- Over 800,000 registrations&lt;br&gt;- 36,834 unique visitors per month, on average&lt;br&gt;- 3,154,840 pages accessed per month, on average</td>
</tr>
<tr>
<td><strong>myCompass</strong>&lt;br&gt;Black Dog Institute&lt;br&gt;www.mycompass.org.au</td>
<td>- Key audience: people with mild-mod depression and anxiety&lt;br&gt;- Fully automated online intervention for depression and anxiety, delivered via computer, mobile phone or tablet&lt;br&gt;- Cognitive behavioural therapy, problem solving therapy, positive psychology and interpersonal psychotherapy delivered via 12 interactive self-help modules&lt;br&gt;- Real time tracking/monitoring of symptoms</td>
<td>- 4,545 unique visits per month, on average (users and general public)&lt;br&gt;- 310 registrations per month, on average&lt;br&gt;- 24,711 page view per month, on average&lt;br&gt;- 15,028 registered users since June 2012</td>
</tr>
<tr>
<td><strong>SHADE</strong>&lt;br&gt;National Drug and Alcohol Research Centre, UNSW&lt;br&gt;www.shadetreatment.com</td>
<td>- Key audience: people aged 18 years and over with depression and comorbid substance use problems&lt;br&gt;- Fully automated online intervention incorporating CBT, motivational enhancement training, mindfulness and relapse prevention&lt;br&gt;- Minimal therapist assistance (10-15 minutes per session) via email, telephone or in clinic&lt;br&gt;- Available in 10-session programme (weekly sessions) or a skills module version (1-2 hours each)</td>
<td>- Clinician supported version of the programme is only offered via research group in Australia</td>
</tr>
<tr>
<td><strong>ThisWayUp</strong>&lt;br&gt;St Vincent’s Hospital&lt;br&gt;www.thiswayup.org.au</td>
<td>- Key audience: people with common mental health problems&lt;br&gt;- Online clinic for registered health providers and their patients&lt;br&gt;- CBT for major depressive disorder, generalized anxiety disorder, panic disorder, social phobia, obsessive compulsive disorder, and co-morbid anxiety and depression&lt;br&gt;- Self-help web intervention for mixed anxiety and depression, crisis management, social phobia&lt;br&gt;- Online courses for schools to teach students how to manage depression and anxiety, alcohol and drugs</td>
<td>- 1,000 unique visitors per month, on average&lt;br&gt;- Clinic site: 80 patient and 40 clinician registrations per month on average&lt;br&gt;- 275 self-help site registrations per month, on average&lt;br&gt;- 500 primary and high schools registered to use the courses as part of their lessons</td>
</tr>
</tbody>
</table>

#### Recovery and Mutual Support Services

<table>
<thead>
<tr>
<th>Service Organisation</th>
<th>Key Audience and Services Provided</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BlueBoard</strong>&lt;br&gt;<a href="http://blueboard.anu.edu.au">http://blueboard.anu.edu.au</a></td>
<td>- Key audience: people with common mental health problems&lt;br&gt;- Moderated internet support group&lt;br&gt;- Available 24/7; moderated 7am-10pm&lt;br&gt;- Separate bulletin board forums for depression, bipolar, anxiety, social anxiety, panic disorder and borderline personality disorder</td>
<td>- 110 new member registrations per month&lt;br&gt;- 6,073 posts per month, on average&lt;br&gt;- 5,408 unique visitors per month, on average&lt;br&gt;- 210,671 pages accessed per month, on average</td>
</tr>
</tbody>
</table>
### Table 2 – CLINICAL EFFECTIVENESS and COST EFFICIENCY of AUSTRALIAN eMH SERVICES

<table>
<thead>
<tr>
<th>Name of programme</th>
<th>Number of research trials</th>
<th>Effect sizes</th>
<th>Cost data</th>
<th>Setting</th>
<th>Target and Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH PROMOTION, WELLNESS PROMOTION AND PSYCHO-EDUCATION SERVICES</strong></td>
<td></td>
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<tr>
<td>BluePages <a href="http://bluepages.anu.edu.au">http://bluepages.anu.edu.au</a></td>
<td>1 x RCT (quasi indicated prevention)</td>
<td>Within group effect size: d=0.4 (depression symptoms) and d=0.5 for completers Between group effect size d=0.29 (depression symptoms) and d=0.35 for completers (12m follow up)</td>
<td>Community</td>
<td>Depression symptoms, depression literacy; reductions in stigma (7, 8)</td>
<td></td>
</tr>
<tr>
<td><strong>PREVENTION, EARLY INTERVENTION AND SUICIDE PREVENTION</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>BiteBack <a href="http://www.biteback.org.au/">http://www.biteback.org.au/</a></td>
<td>1 x RCT</td>
<td>Between group effect sizes: overall d=0.22 (depression symptoms) d=0.34 (high adherence users)</td>
<td>Open access, Australia-wide, community-based trial</td>
<td>Well-being, resilience, depression and anxiety symptoms (15)</td>
<td></td>
</tr>
<tr>
<td>Climate schools <a href="http://www.climateschools.com.au">www.climateschools.com.au</a></td>
<td>3 x RCTs</td>
<td>Within group effect sizes at post: d=0.23 (average alcohol consumption), d=0.2 (binge drinking). AT 6 month follow up: d=0.18 (average alcohol consumption), d=0.19 (cannabis use) At 12 month follow-up: d= 0.38 (average alcohol consumption), d=0.17 (binge drinking); d=0.31 (cannabis use)</td>
<td>Australian secondary school students</td>
<td>Alcohol and drug use, alcohol and drug knowledge, alcohol and drug-related harms, overall well-being. (16)</td>
<td></td>
</tr>
<tr>
<td>eCouch <a href="http://ecouch.anu.edu.au">http://ecouch.anu.edu.au</a> (see also: treatment data)</td>
<td>4 x RCT quasi indicated prevention trials + 1 x equivalence trial</td>
<td>University/staff users social anxiety stream e-couch; Between group pre-post difference: d=0.71 – 0.93 (for social anxiety). Spontaneous users; e-couch depression IPT and CBT streams: Within group d= 0.80 (ITT) and d=1.44 for completers (depression, CBT); d= 0.67 (ITT) and d=1.02 (completers) (depression, IPT) Cardiovascular disease; d=0.18 (depression) and d=0.16 (anxiety)</td>
<td>Community/young people in the community People with cardio vascular disease</td>
<td>Depression and anxiety (30, 48, 49)</td>
<td></td>
</tr>
<tr>
<td>MoodGYM <a href="http://moodgym.anu.edu.au">https://moodgym.anu.edu.au</a></td>
<td>8 quasi indicated prevention; 1 x universal prevention</td>
<td>Within group effect sizes: d=0.4 (depression) and d=0.6 for completers Between group: g=1.19 (depression) and g=0.23 (alcohol misuse)(6 months) Between group: g=0.57 (depression), g=0.74 completers and g=0.82 compliers</td>
<td>Cost effective to translate into another language: 16 QALYS gained per 1,000 treated persons; CER=3,432</td>
<td>Community, schools, universities, lifeline, workplace, NHS choices, Brain Injury (17, 46, 50)</td>
<td></td>
</tr>
<tr>
<td>Name of programme</td>
<td>Number of research trials</td>
<td>Effect sizes</td>
<td>Cost data</td>
<td>Setting</td>
<td>Target and Reference</td>
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</tr>
<tr>
<td><strong>CRISIS INTERVENTION AND SUICIDE PREVENTION</strong></td>
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</tr>
<tr>
<td>Lifeline 13 11 14  <a href="https://www.lifeline.org.au/">https://www.lifeline.org.au/</a></td>
<td>N/A</td>
<td>N/A</td>
<td>Social Return on Investment study of Lifeline Online Crisis Support Chat service in 2013 calculated a return of $8.40 for this service.</td>
<td>Community based adults</td>
<td>Crisis intervention with suicidal Australians (19)</td>
</tr>
<tr>
<td><strong>TREATMENT AND E-THERAPY SERVICES</strong></td>
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<tr>
<td>BraveOnline  <a href="http://www.brave.psy.uq.edu.au/index_brave.html">http://www.brave.psy.uq.edu.au/index_brave.html</a></td>
<td>3 X RCTs</td>
<td>Within group effect sizes at 12 month follow up d=1.85 (child self-reported anxiety); d=2.58 (Clinician Severity Rating)</td>
<td></td>
<td>Adolescents with anxiety</td>
<td>Anxiety symptoms (18, 51)</td>
</tr>
<tr>
<td>e-couch <a href="https://ecouch.anu.edu.au">https://ecouch.anu.edu.au</a></td>
<td>3 X RCTs + 1 equivalence trial</td>
<td>e-couch community users: Between group effect size d=2.43 (generalised anxiety) University/staff social anxiety stream: Between effect (social anxiety 'cases') OR=1.7 (social anxiety) Community users e-couch: Between effect (depression 'cases'): OR=5.3 (depression) Spontaneous users e-couch CBT: within group effect sizes (depression 'cases'): d=0.65 (ITT, 6 mths; depressive symptoms).</td>
<td></td>
<td>Community (Metro/ regional/rural) University</td>
<td>(30, 31, 48)</td>
</tr>
<tr>
<td>Mental Health Online <a href="https://www.mentalhealthonline.org.au">https://www.mentalhealthonline.org.au</a></td>
<td>Uncontrolled ongoing ‘real world’ open access service results</td>
<td>Within group effect sizes: Social anxiety automated: d=0.84; Post traumatic stress disorder automated: d=0.72; Obsessive compulsive disorder automated: d=0.83; Panic automated: d=1.12; Generalised anxiety disorder automated : d=1.22; GAD Online: Therapist-assisted vs face-to-face 59% cost saving; Self-help vs face-to-face 61% cost saving Panic Online iCBT $350 vs. telephone CBT $378 vs. psycho-education only $55 PTSD Online (V1) PTSD ONLINE found to be 3.7 times less expensive than the current cost for psychological therapist time in the traditional face-to-face modality. Anxiety Online (whole service) Estimated labour time cost saving resulting from the Anxiety Online service in the first 18 months of operation is therefore estimated at AU $6.7 million.</td>
<td></td>
<td>Open access real world</td>
<td>Primary and secondary mental health symptoms, number of disorders, confidence in managing mental health and psychological distress (52-54)</td>
</tr>
<tr>
<td>Name of programme</td>
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<tr>
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<td></td>
</tr>
<tr>
<td>MoodGYM <a href="http://moodgym.anu.edu.au">http://moodgym.anu.edu.au</a></td>
<td>8 x RCT + 2CTs + 1 equivalence trial + 1 uncontrolled trial (one TBI)</td>
<td>Within group effect sizes: d=0.9 (depression caseness) completers&lt;br&gt;Callers Lifeline; Between group effect 6 mths (depression ‘cases’): 1.2 (ITT) and 1.4 completers&lt;br&gt;Spontaneous users: Within group effect (depression ‘cases’): =0.61 and 1.36 for completers (at 6 mths). University students between group: g=0.68-0.86 (mild to severe depression ‘cases’) completers and g=0.40-0.90 compliers, Guided primary care between group effect size at post: d=0.65 &amp; d=1.1</td>
<td></td>
<td>Spontaneous users; schools; universities; primary care (GP supported); psychologists; Lifeline; NHS Choices online health portal; public mental health services; brain injury</td>
<td>(30, 55, 56)</td>
</tr>
<tr>
<td>myCompass <a href="http://www.mycompass.org.au">www.mycompass.org.au</a></td>
<td>1 x RCT 1 x uncontrolled trial (diabetes related distress)</td>
<td>Between group effect sizes at post: myCompass vs attention control - d=0.36 (depression); d=0.4 (anxiety); d=0.22 (stress); d=0.22 (work and social adjustment)&lt;br&gt;myCompass vs waitlist d=0.46 (depression); d=0.47 (anxiety); d=0.35 (stress); d=0.29 (work and social adjustment)&lt;br&gt;Within group effect sizes myCompass d=0.24 (anxiety)-0.49 (depression, work and social adjustment)&lt;br&gt;Diabetes trial within group effect sizes at post (unpublished): d=1.05 (depression); d=0.68 (anxiety); d=0.04 (work and social); d=1.15 (diabetes distress)&lt;br&gt;Diabetes within group effect sizes at 3 month follow up: d=0.74 (depression); d=0.48 (anxiety); d=0.57 (work and social); d=1.04 (diabetes distress)</td>
<td></td>
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<td></td>
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<tr>
<td>OnTrack <a href="http://www.ontrack.org.au">www.ontrack.org.au</a></td>
<td>1 x RCT 1 x pilot</td>
<td>Between group effect sizes at 3 month follow up: Unguided brief vs full intervention: d=0.55 (depression); d=0.42 (psychological quality of life)</td>
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</tr>
<tr>
<td>SHADE <a href="http://www.shadetreatment.com">www.shadetreatment.com</a></td>
<td>2 x RCTs 3 x pilots</td>
<td>At 12-month follow-up: DEPRESSION: Clinician-assisted SHADE (d=0.97) vs. therapist-delivered CBT (d=1.16), vs. 1-session (d=0.71), vs. supportive counselling (d=1.03); ALCOHOL: Clinician-assisted SHADE (d=0.87) vs. therapist-delivered CBT (d=1.05), vs. 1-session (d=0.85), vs. supportive counselling (d=0.75); CANNABIS: Clinician-assisted SHADE (d=0.75) vs. therapist-delivered CBT (d=0.53), vs. 1-session (d=0.07), vs. supportive counselling (d=0.17). SHADE used a minimum of 50% less clinician time than the specialist therapist-delivered CBT to produce equivalent outcomes through to 3-years post-treatment</td>
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</table>
## TREATMENT AND E-THERAPY SERVICES (continued from previous page)

<table>
<thead>
<tr>
<th>Name of programme</th>
<th>Number of research trials</th>
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<th>Cost data</th>
<th>Setting</th>
<th>Target and Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This Way Up</strong>&lt;br&gt;www.thiswayup.org.au</td>
<td>4 x RCT</td>
<td>CCCBT+Tel vs CCBT+Forum. Within group effect sizes d=1.31-1.54&lt;br&gt;cCBT vs waitlist: Within group d=0.98; between group d=0.75&lt;br&gt;Worry vs waitlist: within group effect size d=1.3 and between group effect size d= 1.1&lt;br&gt;Social phobia: within group effect size d=0.86 (auto) and 1.15 (reminders)</td>
<td>This Way Up Clinic&lt;br&gt;$1800/DALY averted;&lt;br&gt;This Way Up self-help programme&lt;br&gt;$800/DALY averted</td>
<td>Community volunteers with social phobia, depression, anxiety&lt;br&gt;82 volunteers with social phobia&lt;br&gt;45 diagnosed with depression&lt;br&gt;48 diagnosed with anxiety&lt;br&gt;163 with social phobia</td>
<td>Shyness (59); depression(60); anxiety ; social phobia</td>
</tr>
</tbody>
</table>

## RECOVERY AND MUTUTAL SUPPORT SERVICES

<table>
<thead>
<tr>
<th>Name of programme</th>
<th>Number of research trials</th>
<th>Effect sizes</th>
<th>Cost data</th>
<th>Setting</th>
<th>Target and Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BlueBoard</strong>&lt;br&gt;<a href="http://blueboard.anu.edu.au">http://blueboard.anu.edu.au</a></td>
<td>1 x RCT</td>
<td>Unguided community users: BlueBoard (adapted): Between group effect: Odds Ratio = 12.5. (12 mths)&lt;br&gt;Unpublished data – Within group effect size for spontaneous BlueBoard users - completers: d= 0.58 (depression)</td>
<td>Online support group for people with depression</td>
<td>Depression (31, 61)</td>
<td></td>
</tr>
</tbody>
</table>
Table 3 – STRATEGIC INVESTMENT SUMMARY

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Benefits</th>
<th>Strategic Response</th>
<th>Solution Changes</th>
<th>Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many people with a mental health problem do not get treated in the community</td>
<td>KP1 More Australians will know about mental health services available through the internet</td>
<td></td>
<td>Awareness campaigns to raise understanding of the availability, safety and efficacy of eMH services</td>
<td>Leverage existing relationships and Funding through Teleweb and other measures</td>
</tr>
<tr>
<td></td>
<td>KP2 More Australians will seek these services</td>
<td></td>
<td>eMH services offered through a ‘chain or ecosystem of care’ which takes account of severity and time need</td>
<td></td>
</tr>
<tr>
<td>The current GP and mental health services systems are overloaded with consumers who may benefit from eMH health resources.</td>
<td>KP1 More Australians will receive evidence based psychotherapy through a stepped care approach</td>
<td></td>
<td>Integration of face-to-face and eMH services to reflect need</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KP2 More Australians are referred to appropriately tailored services, as well as being referred in and out of eMH services</td>
<td></td>
<td>Education programmes for health professionals and GPs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>KP3 More GPs, psychologists, allied health professionals and NGOs will be trained and feel confident to use eMH tools</td>
<td></td>
<td>New items/measure for accreditation of effective services, products and devices</td>
<td></td>
</tr>
<tr>
<td>The costs of GP systems are mounting</td>
<td>KP1 Costs per person will decline as 30% are expected to respond to automated/less costly care/ with majority in mild-to-moderate.</td>
<td></td>
<td>eMH will be offered as a preferred first step treatment in primary care</td>
<td></td>
</tr>
<tr>
<td>Common mental health problems are treated too late, and the window for prevention is missed</td>
<td>KP1 New cases are identified and treated by eMH programmes in schools, universities and workplaces. Prevalence drops by 22% through prevention programmes.</td>
<td></td>
<td>Prevention programmes in schools, universities and workplaces use evidence-based eMH</td>
<td></td>
</tr>
<tr>
<td>Consumers feel they are not supported in their recovery and demand better services</td>
<td>KP1 More Australians will communicate through online recovery boards and where appropriate be referred to other services</td>
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<td>More managed eMH recovery services with potential for linkage to face-to-face services</td>
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<td>KP2 Consumers will be supported through peer-to-peer support mechanisms.</td>
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REFERENCES


