



(REVIEW ARTICLE)



ENHANCING MENTAL HEALTH ACCESS: A TELEHEALTH APPROACH FOR RURAL YOUNG ADULTS

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ABSTRACT

The rural young adults between 18 and 25 years are still among the most underserved groups in the systems of global mental health with compounded stigma, provider shortages, geographic isolation, and limited digital infrastructure. The literature review will focus on the importance of telehealth as a tool of increasing access to mental health among this population based on five empirical studies published between the years 2020 and 2024. The study was a synthesis of evidence on qualitative, quantitative, mixed-method, and conceptual research studies carried out in the United States, Australia, and other global locations using a structured review methodology.

The evidence points to the constant moderate to high effectiveness of telehealth interventions in the form of video consultations, smartphone-based applications, computerized cognitive behavioral therapy (cCBT), and telepsychiatry in terms of minimizing the level of depressive symptoms and improving access to services among rural young adults. Telehealth was discovered to minimize transportation obstacles, enhance adherence to appointments as well as greater parental involvement where applicable. Nevertheless, as the evidence also indicates, there are essential constraints as telehealth itself is not enough when dealing with people with complex neurodevelopmental models. The lack of effective digital connectivity weakens the coverage of services, and the relationship aspects of therapy are more problematic to build in remote modalities. Irrespective of the modality of delivery, stigma, lack of mental health literacy, and confidentiality issues continue to be key impediments to help-seeking among this group of people.

It is concluded that telehealth has a high potential as a supplementary approach in the framework of a blended care model of rural young adults but should be supported by structural investments in digital infrastructure, workforce training, and anti-stigmatization efforts.

Keywords: Telehealth, Mental health, Rural young adults, Mental health access, Digital mental health, Rural healthcare disparities.

1 INTRODUCTION

Mental health conditions are one of the largest and the most increasing social issues in the twenty-first century. The World Health Organization (2022) reports that approximately one billion individuals in the world experience a mental condition, but most of them lack quality care. The treatment gap is still worrisome in most low- and middle-income countries and in rural areas of high-income countries, less than 20% of the population with a mental health condition receives the relevant services (WHO, 2022). One of the most vulnerable groups is represented by young adults aged between 18 and 25 as this is the period of their development when they are more prone to developing anxiety, depression, and other psychiatric disorders (Arnett et al., 2014). Rural populations also have compounded mental health care issues such as geographic distance, lack of trained mental health workers, transportation challenges and in-depth stigma on the seeking of psychological assistance (Smalley et al., 2010). Such structural injustices imply that young rural adults are underserved more than their urban counterparts, as they also have similar or even higher mental health demand levels (Borders & Booth, 2007). The combination of rural and youth thus forms a very crucial access gap requiring an innovative and specific solution.

Telehealth has become a new revolutionary tool in the process of eliminating disparities in health care delivery, especially to the underserved populations. Telehealth can be described as the application of digital communication technology in offering health services remotely in a broad sense, and it has demonstrated a lot of potential in enhancing access to mental health care among the population who would otherwise lack support (Hilty et al., 2013). Although there is increasing evidence of its effectiveness, the uptake of telehealth in rural mental health settings is uneven, and the particular application of it to young adult groups should be the topic of further research in the scholarly community. The literature review aims to investigate and integrate previous studies on the application of telehealth as a method of increasing access to mental health among young rural adults. The objectives that will guide the review include: (1) understanding the nature and scope of barriers to access mental health among rural young adults; (2) understanding the effectiveness and acceptability of telehealth interventions among this group; and (3) identify gaps in the literature and implications of the policy and practice. This review can help expand the body of knowledge that can be used to deliver mental health services more fairly and responsively by meeting these goals.

1.1 Conceptual Clarifications

1.1.1 Telehealth

Telehealth is a multidimensional concept that is quite broad and covers the provision of the health-related services and information using the electronic and telecommunications technologies. According to the definition by the Health Resources and Services Administration (HRSA, 2021), telehealth refers to the application of electronic information and telecommunications technologies in providing support and encouragement to long-distance clinical health care, patient and professional health-related education, and the enhancement of public health and health administration. Telehealth within a mental health setting has a variety of forms, such as synchronous video calls, asynchronous messages and email-based therapy, mobile health (mHealth) apps, telephone counselling, and online-based cognitive behavioral therapy (iCBT) systems (Lal and Adair, 2014).

Telehealth needs to be differentiated with the concept of telemedicine, which is more specific, as it does not imply more than the delivery of clinical services by licensed medical professionals through distance (Bashshur et al., 2014). Telehealth on the other hand is a more general umbrella term that encompasses non-clinical services in the form of health education, care coordination as well as administrative activities. To address this review, telehealth is perceived in a broad context, but with specific reference to tele-mental health that is, the use of telehealth technologies in mental health assessment, diagnosis, treatment and support. This difference is essential since tele-mental health requires specific ethical, clinical, and technological implications that are not similar to the rest of the medical telehealth practice (Shore et al., 2018).

1.1.2 Mental Health Access

Mental health access can be described as the capacity of people to access quality mental health services at the right time, in the right manner, and at the right cost. In one of the earliest conceptualizations that continue to be referenced to this day in the modern health services research, Penchansky and Thomas (1981) distinguished five dimensions of access, namely availability (supply of services), accessibility (geographic proximity), accommodation (organizational factors), affordability (financial feasibility), and acceptability (social and cultural congruence between services and users). Systemic factors such as stigma, mental health literacy, insurance or funding gaps also complicate access in the mental health domain (Clement et al., 2015).

The physical access to mental health services cannot be limited to simple physical distance to a treatment provider; it is also required to consider the psychological, cultural, and structural factors that either support or hinder the help-

seeking behavior. Among rural populations, the barriers to access work along several dimensions in tandem with each other, such as distance to specialized services, limited access to psychiatrists and clinical psychologists, and cultural beliefs that might prevent the recognition of psychological distress (Mojtabai et al., 2011). It is important to know that mental health access is a multi-dimensional construct and as such, to understand the possibilities of telehealth in tackling service gaps in rural young adults.

1.1.3 Rural Healthcare

Even the notion of rurality is a matter of contention and operationalization in different national environments. The Office of Management and Budget (OMB) of the United States draws the distinction between metropolitan and non-metropolitan areas depending on the population density and commuting patterns, and the Rural-Urban Continuum Codes (RUCC) created by the United States Department of Agriculture (USDA) is more detailed, with 9 levels of classification (USDA Economic Research Service, 2013). In Australia, geographic remoteness is also categorized under the modified Monash Model (MMM) to be used in the health workforce planning. Under these frameworks, rural healthcare is a broad term that is used to refer to provision of health services in non-urban areas that are characterized by low population density, long distance to tertiary health facilities and low availability of specialists (Wakerman and Humphreys, 2011).

The rural healthcare is differentiated not only by the geographic features but also by socio-economic and structural factors which influence the outcomes in health. The rural population is characterized by worse rates of chronic disease, lower socioeconomic status, and access to preventive health services in comparison with urban population (Singh and Siahpush, 2014). Mental health services are always some of the least delivered in rural healthcare, and in most rural regions, specialized psychiatric care is not accessible to the residents within a reasonable distance. The maldistribution of mental health workforce also contributes to this shortage as it is very much concentrated in urban and suburban centers (Thomas et al., 2009).

1.1.4 Young Adults

Young adulthood is generally a social construct used to describe the age group of 18 to 25 years, but some developmental models go up to 29 years as the society today takes longer periods to become an adult (Arnett, 2000). This developmental stage is defined by Arnett influential theory of emerging adulthood which describes the stage as a developmental phase characterized by identity exploration, instability, self-focus, feeling in-between as well as the perception of possibilities which makes young adults especially vulnerable to psychological distress (Arnett, 2000). Epidemiological evidence has shown that most lifetime mental health disorders are onset before the age of 25 and early intervention in young adulthood is a very important priority in the public health (Kessler et al., 2005). Young adults are a vulnerable population at risk and chronically under-served in the context of mental health services research. Although the prevalence of depression, anxiety, substance use, and suicidality is high, young adults are one of the least age groups that receive formal mental health care (Gulliver et al., 2010). The population-specific barriers are fear of stigma, fear of confidentiality, self-management preference and insufficient awareness of the available services. In cases where rurality meets young adulthood, these obstacles are only compounded, which presents a particularly acute and understudied challenge to the mental health systems.

2 METHODOLOGY

This review utilized the systematic empirical methodology to integrate evidence about tele-mental health access among rural young adults. Five studies that were published in the years 2020-2024 were used which were conducted in different geographic settings such as the United States, Australia, and worldwide. The chosen articles included qualitative studies (Svistova et al., 2022), systematic and literature reviews (Smeenk, 2020; Radez et al., 2020), mixed-method assessments (Fisher et al., 2024), and theoretical opinions (Morales et al., 2020). The inclusion criteria were that the studies had to be adolescent or young adult and should be transitioning to young adulthood (around 18-25 years) and that should include rural populations and tele-mental health intervention. The ones that were included focused on access, barriers, facilitators, or outcomes of digital mental health services. The exclusion criteria were used to exclude studies that only covered urban populations, not related interventions, or populations that were not within the target age range. Data extraction was achieved through tabulating the important study attributes, such as author(s), year, country, study aims, methodology, sample characteristics, key findings, conclusions, and gaps identified. This systematic methodology facilitated comparison of different study designs, which identified patterns, limitations and gaps that were unique to rural youths who use tele-mental health services. The methodology is transparent and replicative in synthesizing the existing empirical evidence.

Table 1: Summary of Empirical Studies on Tele-Mental Health Access for Young Adults

Author(s) and Year (Country)	Aim of the Study (Young Adult Focus)	Methodology	Sample/Population (Young Adult Focus)	Key Findings Related to Young Adults	Conclusions Related to Young Adults	Identified Gap / Limitation Related to Young Adults
Swistova et al. (2022) - USA	To explore mental health providers' experiences using telehealth to deliver services to rural youth, including transition-age youth approaching young adulthood.	Qualitative study using online focus groups analyzed through grounded theory techniques.	147 providers (119 service providers and 28 Medicaid Managed Care Organization representatives) serving youth ≤ 18 and elderly populations in rural Pennsylvania.	Telehealth enabled service continuity, improved parental involvement, reduced transportation barriers, and lowered appointment no-show rates. However, it was less effective for some youth with conditions such as autism, ADHD, and impulse control disorders.	Telehealth offers promising opportunities for improving mental health service accessibility for rural youth transitioning into young adulthood, but it is not suitable for all individuals and requires complementary service approaches.	Findings rely solely on provider perspectives without input from young adults themselves. Medicare and private insurers were not included, and most data focus on individuals under 18 years rather than the 18–25 age group.
Smeenk (2020) - USA	To evaluate technology-based and tele-mental health interventions for adolescents and young adults (13–29 years) living in rural areas of the United States.	Comprehensive literature review of meta-analyses, systematic reviews, and randomized controlled trials conducted between 2005 and 2019.	Studies involving adolescents and young adults aged 13–29 years.	Smartphone-based mental health interventions demonstrated moderate positive effects in reducing depressive symptoms among young adults ($g = 0.383$). Computerized cognitive behavioral therapy (cCBT) showed small-to-moderate effects ($g = 0.16–0.62$). Telepsychiatry was found	Digital and tele-mental health interventions represent viable treatment options for managing mental health conditions among young rural adults but should complement rather than replace in-person therapy.	Many studies reviewed had small sample sizes and lacked long-term follow-up. Rapid technological changes also outpace the timelines of controlled trials, limiting evidence stability.

				to be comparable in effectiveness to traditional face-to-face therapy.		
Fisher et al. (2024) – Australia	To evaluate the reach and effectiveness of the Isaac Navicure care navigation service in improving mental health service access for rural residents, including young adults.	Mixed-methods implementation science evaluation using the RE-AIM framework, incorporating database analysis, surveys, and semi-structured interviews.	197 clients (128 adults and 69 minors) in Queensland, Australia; the adult category included individuals aged 18–25, though data were not disaggregated for this group.	Most clients preferred face-to-face services (85.4%), but the majority of referrals were directed toward telehealth due to limited local providers. Establishing trust and rapport with care navigators significantly increased willingness to try telehealth services. Key barriers included poor connectivity, privacy concerns, and challenges developing therapeutic relationships online.	Telehealth alone cannot adequately address mental health service gaps among young rural adults. Combining telehealth with personalized care navigation significantly improves acceptance and engagement.	Low survey response rate (6.8%) and lack of disaggregated data for the 18–25 age group limit the interpretation of findings for young adults specifically.
Radez et al. (2020) – International	To identify barriers and facilitators influencing professional mental health help-seeking among children and adolescents, with implications for older adolescents transitioning into young adulthood.	Systematic review of 53 quantitative and qualitative studies.	Children and adolescents aged ≤18 years, with particular relevance to older adolescents aged 16–18 transitioning to young adulthood.	Major barriers included stigma and embarrassment (reported in 76% of studies), preference for self-reliance (39%), poor mental health literacy (53%), and concerns about confidentiality (28%). Facilitators included encouragement	Effective interventions for young adults should prioritize stigma reduction, improved mental health literacy, and the promotion of confidential and accessible services.	Most studies focused on adolescents rather than young adults aged 18–25. Additionally, many quantitative studies lacked standardized diagnostic assessments.

				nt from family and friends and previous positive help-seeking experiences.		
Morales et al. (2020) - USA	To apply the National Institute on Minority Health and Health Disparities (NIMHD) research framework to understanding rural mental health disparities affecting young adults.	Perspective and conceptual review article.	Focus on rural populations, with specific attention to young adults aged 25–34 and adolescents aged 10–14.	Young adults aged 25–34 experience suicide rates nearly four times higher than adults older than 34. Major barriers include provider shortages, geographic isolation, stigma, lack of insurance coverage, and easy access to lethal means in rural communities.	Addressing rural young adult mental health disparities requires multi-level research frameworks and culturally appropriate prevention strategies that address social, environmental, and healthcare system factors.	The article does not provide primary empirical data and calls for further research testing causal mechanisms and intervention strategies specifically targeting rural young adults.

3 DISCUSSION

The results of this review lead to one main idea, that telehealth is a feasible and more and more required tool of expanding mental health care to rural young adults, however, its application should be based on the realities of the structural, developmental, and contextual particularities of this group. In all five articles under review, there was a strong trend observed in that telehealth has the power to decrease access barriers in logistics but does not in and of itself decrease the more profound psychological and systemic barriers that prevent mental health help-seeking among youth in rural areas. The qualitative data presented by Svistova et al. (2022) in a rural Pennsylvania area were highly convincing as they showed that telehealth allowed continuing the service where it could not be provided face-to-face, minimized the failure to reach the appointments due to transportation, and helped parents to participate in the process of treating youth mental health. These results can be attributed to the larger literature on the topic that indicates that geographic barriers in rural environments are one of the most manageable issues that telehealth can address (Hilty et al., 2013). It is noteworthy, though, that Svistova et al. found that telehealth was significantly less useful in young individuals with autism spectrum disorder, ADHD, and impulse control disorders, which highlights the importance of the clinician-led triage to ensure the modality suitability to the specific clients.

A literature review of meta-analyses and randomized controlled trials by Smienk (2020) found moderate positive effects of smartphone-based interventions on depressive symptoms reduction in young adults aged 13 to 29 ($g = 0.383$), and small-to-moderate effect sizes of computerized CBT ($g = 0.16-0.62$). More importantly, it was discovered that telepsychiatry was statistically equivalent in its effectiveness to face-to-face psychiatric care. These numerical results hold a lot of weight to the rural health policy since they undermine the long-standing assumption that remote care is worse than face-to-face care (Lal & Adair, 2014). The relational dimension, which is significant to the evidence, was presented in the mixed-methods evaluation of the Isaac Navicare service conducted by Fisher et al. (2024) in Queensland, Australia. Although most referrals were made to the telehealth as a result of the lack of local providers, 85.4% of clients indicated that they would prefer to use face-to-face services. Such a preference difference points to the difference between access-based adoption and actual therapeutic choice and presents ethical issues to the extent to which rural populations can provide meaningful consent to telehealth where other options are structurally inaccessible. Fisher et al. also discovered that the relationship between care navigators played a critical role in enhancing the desire of clients to use telehealth, which also concurs with the emerging evidence on the role of navigated care models to encourage healthcare participation in marginalized populations (Browne et al., 2017).

In a systematic review of 53 qualitative and quantitative studies, Radez et al. (2020) found stigma and embarrassment to be the most frequently reported barriers to professional help-seeking in adolescents and young people, and they were reported in 76% of the studies. In 53% of the studies, poor mental health literacy was mentioned, and in 28% of the studies, the issues of confidentiality. The findings play a vital role in the awareness of why telehealth cannot be used to bridge the mental health access gap: despite making services digitally available, young adults might not utilize them due to the lack of knowledge, trust, or absence of social shame. This observation requires that telehealth services to young adults in the rural communities be accompanied by strong community based mental health literacy interventions and guarantees of confidentiality (Gulliver et al., 2010).

Lastly, with references to the National Institute on Minority Health and Health Disparities (NIMHD) research framework, Morales et al. (2020) provided a structural analysis of mental health disparities in rural settings and discovered that young adults, aged 25 to 34 years, are at risk of suicide almost four times as often as older adults. The authors placed these inequalities in the context of multilevel structures of disadvantage, which includes provider shortage, insurance disparities, geographic seclusion, and cultural beliefs that condone stoicism in the face of psychological suffering. This structural lens is needed to put the promise of telehealth into perspective: technology can be used to increase access but not offset the lack of universal mental health coverage, care responsive to cultural factors, and community infrastructure. These results are consistent with those of Smith et al. (2020), who have shown that the digital divide, or a set of disparities in internet access and digital literacy, can reproduce and even exacerbate existing rural health inequities in the case of the introduction of telehealth without any equity-centered implementation plans.

Collectively, the reviewed studies indicate a blended care model as the most evidence-appropriate to use with rural young adults: that is, a model where telehealth acts as an access point to mental healthcare that is flexible and can be used in a wide variety of manners, as opposed to a wholesale substitute of face-to-face therapeutic relationship. The personalized care navigation, culturally responsive programmed design, investment in digital infrastructure, and meaningful youth engagement in service co-design should be the basis of this model.

3.1 Implications of the Study

The implications of the findings include clinical, policy, and systemic implications. Telehealth ought to be recognized as a good modality of managing depression and anxiety among young adults living in the rural setting and the clinicians involved in telehealth should have the training in digital therapeutic alliance-building and modality-matching. Telehealth will never resolve the service gaps in rural areas on its own; the structural changes are required, such as the maldistribution of the workforce, Medicare/Medicaid reimbursement, and rural broadband investment. The care navigation model improves access and participation at the same time. On a systemic level, stigma and poor mental health literacy must be addressed through interventions on a population level through schools, community organizations, and peer networks. The extra support is necessary to ensure that the quality and therapeutic integrity are upheld, where telehealth is the sole alternative. Altogether, telehealth has to be integrated into a larger ecosystem of structural, educational, and relational resources to be effective in enhancing the outcomes of mental health in young adults in rural settings.

3.2 Recommendations

There are a number of recommendations for practice, policy, and research that are supported. To start with, rural mental health services should implement blended care models that combine telehealth with the preservation of in-person services for complex cases, such as neurodevelopmental conditions. Second, the work of care navigators needs to be extended to young adults, showing how to use telehealth platforms, including for those who are low in digital literacy or have a negative experience with help-seeking. Third, governments should focus on broadband infrastructure in rural areas to minimize access inequities. Fourth, the mental health literacy and anti-stigma programs must be co-developed with the youth and provided through the trusted community channels. Lastly, prospective studies that disaggregate data from the 18-25 cohort are required to fill gaps in the evidence on telehealth effectiveness, engagement, and the equitable provision of services in rural settings.

4 CONCLUSION

The review of the evidence on telehealth to improve access to mental health care for rural young adults was conducted based on barriers, intervention effectiveness, and gaps in the research. A review of five studies (2020-2024) shows that telehealth is a clinically viable means of enhancing access but requires additional structural, educational, and relational supports. Interventions based on smartphones and telepsychiatry have a beneficial impact, whereas care navigation enhances engagement. Mental health literacy and the reduction of stigma are the most important requirements for utilizing it equally. Nevertheless, telehealth in itself poses a threat of perpetuating inequalities by favoring people with good internet access, digital literacy, and culturally competent services. Mental health among young adults in rural areas is therefore an issue of equity, investment, and policy intervention, rather than technology. Well-funded, sustained,

youth-centered systems are necessary. Future studies ought to focus on prospective research which aims at addressing the 18-25 age group to create a strong evidence base on the way to address the mental health requirements of the young adults in a systematic manner to meet the needs of rural settings.

STATEMENTS ON COMPLIANCE WITH ETHICAL STANDARDS

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