DCP Digital Healthcare Committee
Equity and Inclusion Proposal for Digital Practice

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The context for digital practice

The current health and social care context in many parts of the UK is one of transformation. In England, this reflects the ambitions of, for example**,** the Long Term Plan (LTP, 2019), Community Mental health Framework (CMHF, 2019), From Harm to Hope (10 Year Drug Plan; 2021) within the new legal framework of the Health and Social Care Act (2022). These ambitions include a move to: ""*new community-based offer [that] will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use… and proactive work to address racial disparities*."" (CMHF, p.1), highlighting the need to embed equalities thinking into the planning and delivery commitments in local health systems (NHS England, 2019).

Indeed, the British Psychological Guidance "*Using Community Psychology approaches to reduce the impact of inequality through the Community Mental Health Framework*" highlights that "*mental health inequalities and their causes can only be addressed… through action on wider social inequalities*", with community based approaches key in achieving this (BPS, 2022 p.1). There are many factors in our life that influence our mental health and intersect with inequalities in society. Intersectionality is defined as "*when an individual's race, gender, disability, sexual orientation and other characteristics or identities overlap or 'intersect' so that they can be affected by a number of discriminations and disadvantages*" (BPS; Diversity and Inclusion | BPS). Key within this is the importance of considering for each individual how the inequalities they face intersect as part of the provision of the "*personalised and trauma informed care"* (CMHF., 2019, p.1) outlined above.

It is well documented that individuals and groups impacted by multiple health, social, racial and economic inequalities and discrimination experience higher levels of poor mental health, yet also the greatest difficulty accessing services (The Centre for Mental Health, 2020; Kings Fund,

2020). Minoritised groups most impacted include, however are not limited to, people experiencing socio-economic difficulties, who identify as LGBTQIA+, asylum seekers and refugee's, people who are neurodiverse, who are labelled as from minoritised (black and minority ethnic) groups, people from gypsy, Roma and traveller communities (Kings Fund, 2002, Centre for Mental Health, 2020). For the purpose of this document, the term minoritised group has been used to describe groups of people overly impacted by the intersection of multiple forms of discrimination and inequalities in the allocation of power and resources (Selvarajah et al., 2020). However, it is acknowledged that the word 'minority' does not accurately reflect that some of the groups mentioned **do** in fact make up the global majority.

Digital Practice in Healthcare

Over the last 20 years, healthcare has begun operating in a digital world. Internationally, policy documents, guidelines and digital programmes have emerged exploring how technology could shape the context of mental health treatment. Across the UK, the National Health Service (NHS) is starting to implement evidence-based digital therapy packages for use in primary care mental health services (Burbach & Pote, 2021; NHS Confederation 2023), for example the seven-module 'Space from Anxiety' programme, which teaches young people CBT skills (Richards et al., 2018). It is well documented digital interventions have the potential to increase accessibility to mental health support for some individuals (Titov et al., 2016; Torous et al., 2020). With a wide range of mental health apps available to the public reported to provide cost effective, usable services that can be accessed from home, rather than people needing to **travel** to a clinic, which can act as a bridge to accessing care (Price et al. 2014; Ralston, Andrews & Hope, 2019).

Examples of apps include; My Compass that delivers customised CBT techniques to adults with anxiety (Proudfoot et al., 2013), and Sleep Ninja that offers six training sessions on sleep hygiene to children (Werner-Seidler et al., 2017). Such innovations have the potential to reach people who experience barriers to accessing face-to-face services, including those with physical disabilities and chronic illnesses (Haig-Ferguson et al., 2019), individuals living in rural areas further away from clinics (Graham et al., 2021), those with caregiving responsibilities (Petrovic & Gaggiolo, 2020) and those in criminal justice settings.

A significant part of the COVID-19 legacy has been the rapid development of online interventions, with reports in some UK areas of a 1000% increase in uptake during the early stages of the pandemic (Webster, 2020). The expansion of online practice enabled psychological services to continue during the COVID-19 pandemic (Pote, 2021). Services had to respond quickly to adapt **to** working flexibly and creatively to meet the needs of clients during these uncertain and difficult times (Bauer-Staeb et al., 2021). However, such rapid expansion did not come without its challenges, including for example an inadequate IT Infrastructure. There is also a significant risk that existing health, social, racial and economic inequalities will continue to impact the accessibility of digital interventions if the current inequalities people may experience are not fully considered. Indeed, such inequalities could be further exacerbated through a growing divide between those with access to digital products and services and those without (Torous et al., 2020). The NHS long Term Plan highlights the need to embed equalities thinking into the planning

and delivery commitments in local health systems (NHS, 2019), we would echo that this is vital to achieve its ambitions. Indeed, one of the recommendations of the independent report 'Putting data, digital and tech at the heart of transforming the NHS' (November 2021) under the heading of 'Mindset: a patient and citizen centred approach' notes that:

*"… the responsibility of the NHSEI Health Inequalities team should be expanded so that digital exclusion is seen as another lens within health inequalities" (*Putting data, digital and tech at the heart of transforming the NHS - GOV.UK (www.gov.uk)).

At the same time as the amount of digital interventions available increased, COVID-19 and the current context of austerity in the UK, turned the spotlight on to already widening health, social and economic inequalities. This is due to the unequal consequences of both of these contexts (COVID-19 and austerity) on financial security, physical health, mental health, trauma and loss for minoritised groups (Rimmer, 2021). The impact and implications of the unprecedented change in service delivery across services as a whole during COVID-19 is yet to be fully evaluated and understood. There is a risk that minoritised communities in particular, who are often excluded from research (Konkel, 2015), will not be prioritised within this research agenda. We suggest that key within both trauma informed service delivery and the research agenda is the need for the way forward to be co-produced.

Co-production

It has been recognised in the literature that individuals and their communities have not always been involved in determining how services can be shaped to effectively reach and support individuals and communities (Beresford, 2013). Assumptions held by services, **that** are more likely to occur where services are structured and designed without participation with citizens (Arnstein, 1969), may also act as a barrier to certain groups accessing digital mental health interventions. For example, whilst clinicians may hold beliefs that older adults are avoidant of technology (Cangelosi & Sorrell, 2014), there is evidence suggesting that older adults can engage with digital interventions as well as, and sometimes better than, their younger counterparts (Hobbs et al., 2018; Reinwand et al., 2015). However, lack of appropriate support from services and adaptations to meet age-related needs can act as barriers to care (Seifert, et al., 2019).

Co-production has been defined by the New Economics Foundation as "*a value driven approach that blurs barriers between the state, services, and citizens; involves relationships of reciprocity and mutuality; and applies an asset-based model of service users*" (Dunston et al. 2009). The NHS Mental Health implementation plan (of the NHS Long Term Plan for England) acknowledges the societal and cultural contexts influencing mental health inequalities and therefore the need for local health systems to co-produce localised solutions with communities (NHS, 2019). Furthermore 'Recommendation 8' of the Five Year Forward View for Mental Health highlights the need to develop evidence based approaches to co-production in commissioning (The Mental Health Taskforce, 2016).

Our suggestion related to the importance of co-production is considered timely, given NHS England note that "*The Health and Care Act 2022 mobilises partners within Integrated Care Systems (ICSs) to work together to improve physical and mental health outcomes"* (2023 p.7) as part of the statutory guidance Working in Partnership with People and Communities. This guidance aims to support e.g. the Integrated Care Boards (ICBs) within Integrated Care Systems (ICS's) in relation to public involvement, noting:

"*While involving people and communities is a legal requirement, working with them also supports the wider objectives of integration including population health management, personalisation of care and support, addressing health inequalities and improving quality. The legal duties provide a platform to build collaborative and meaningful partnerships that start with people and focus on what really matters to our communities*" (p.7).

The hope moving forward is that the fundamental emphasis on involving people with lived experience and their significant others in the design, development and sustaining of trauma informed services that are tailored to need, will ensure this becomes standard practice moving forward. Co-production is considered vital to the development of trauma informed services, with 'Engagement and Involvement' one of the ten 'Implementation Domains' outlined in the SAMHSA's [Substance Abuse and Mental Health Services Administration] Concept of Trauma and Guidance for a Trauma-Informed Approach (SAMHSA., 2014). Co-production is also considered an essential ingredient to unlock the potential for digital tools to effectively support individuals (Murphy, Thorpe, Trefusis, Kousoulis, 2020; Mental Health Network, 2021).

What do we mean by digital inclusion and accessibility?

NHS digital (2019) defines 'digital inclusion' as covering three main areas:

1. Digital skills (ability to use devices)
2. Connectivity (access to the internet)
3. Accessibility (services needing to meeting all users' needs).

In terms of connectivity and digital skills, research indicates that 14.9 million people have low digital use and 10 million people do not have digital skills. Some 1.5 million homes do not have internet access and 2 million households cannot afford internet access (NHS Digital, 2019). This data does not account for the ever-increasing cost of living crisis exacerbated by the context of COVID-19 and public spending budget cuts of 54.6% real term in the area of housing and communities (Office for Budget Responsibility, 2022). The government digital service has developed a digital inclusion scale, which maps individuals' digital capability on a scale from 1 to 9 from those who do not use the internet through to digital experts (NHS Digital, 2019). This has identified population groups more likely to be digitally excluded than others namely, older people, people with lower income, those who have disabilities, those who are unemployed, in social housing, people with fewer educational qualifications, those living in rural areas, experiencing homelessness and those whose first language is not English.

Inequality of access to mental health support is not just about geographical location and accessibility to technology, it is also about services being acceptable, safe and appropriate to meet people's needs. Science has been shaped by the values exemplified by the acronym, Western, Educated, Industrialised, Rich, Democratic (WEIRD; Heinrich et al., 2010). This is reflected in the development of health care models, institutions and workforces, exacerbated by discrimination for staff from minoritised communities (Kline, 2014; Legha & Martinek, 2023). Clinical Psychology is by no means exempt from this. In 2017, White British applicants had a 1 in 5 change of being shortlisted for interview for Clinical Psychology compared to 1 in 13 for people of the global majority (Clearing House, 2017). The current evidence base informing NICE guidelines disproportionately represents WEIRD and has led to an over-emphasis within the profession and institutions of Eurocentric and psychocentric models of distress grounded individualism (Rimke, 2016; Wood & Patel, 2020). The consequences of this are that systemic and political understandings of distress are not considered within the therapy room, leading to the pathologizing of trauma the roots of which are in systemic oppression. Consequently systemic solutions to address the root causes of distress are not as invested in, thus maintaining the inequality of access to effective, safe and trusted support (Bansal et al., 2022, Horsfall, 1998, Joseph, 2015 and Kline, 2014). A report by The Centre of Mental Health's 2020 on the Commission for equity in mental health support states "*It is services, not the people they intend to serve, that need to change to make themselves more accessible, acceptable and appropriate to people's needs*" (p.1).

It is vitally important that those with decision making powers take action to address existing systemic and institutional inequalities. This, combined with the provision of the necessary investment and resources, is vital to support co-production in terms of the design and development of digital interventions that are tailored to the specific needs of different communities. Without this, it is difficult to see how the inequalities currently experienced by minoritised groups will change when accessing appropriate and effective online interventions. The above highlights the critical importance of a transformative equity and inclusion strategy that takes active steps for minoritised communities to be included in the development of health interventions to ensure that digital practice is appropriate, accessible and effective for their specific needs.

An impactful Equity and Inclusion strategy for Digital Clinical Psychology is one that:

- Actively seeks to understand the changes needed to achieve equity of access to digital mental health support and advocates for, and then implements, change at multiple levels.

- Ensures an approach that encompasses respect for diversity of knowledge and expertise, that actively values diverse experience and contribution to achieve better outcomes (NHS, 2020).

- Acknowledges that the methodologies, curricula and research base of clinical psychology are centered on the individual, white European, heteronormative experience (DCP Racial and Social Inequalities in the times of COVID-19 working group, 2020) and seeks solutions to address this.

- Acknowledges the impact of racial, social health and economic disparities for minoritised groups.

- Reflects on and acknowledges prejudices and biases.

- Embeds co-production in service design and delivery (NHS, 2020).

- Is prepared to use funding to co-produce online interventions that are accessible and meet people's needs, whilst recognising 'one size does not fit all' and responding flexibly to situations where alternatives to online interventions are required.

Recommendations

<u>Services working in partnership with individuals and their communities</u>

- For services to consistently build and maintain partnership relationships with local communities, for example faith-based and grass root organizations. Community Power: The evidence, (2021), presents the rationale and recommendations for community led solutions to challenges including health and mental health (Pollard, Studdert, Tiratelli, 2021).

- Actively seek to understand and respond to the needs and voices of those services need to reach, for example, those excluded from digital services, through the funding and implementation of co-produced service development, evaluation and research (Burgess & Choudary, 2021; Filippe, Renedo & Marston, 2017; O'brien et al., 2022).

- Use localised participatory research to understand the needs and perspectives of communities and in relation to digital practice (O'Brien et al., 2022).

- Co-design digital interventions alongside people receiving services (Jones et al., 2020; O'Brien et al., 2022). For example, Ayvaci (2016) notes '*From a research standpoint, there is a strong need to understand faith-based factors that may improve access to mental healthcare*' (p.13). With the co-production collective include examples of how to embed co-production in service provision (The co-production collective, 2023).

- Work to promote and strengthen community resources and organisations, including those seeking to empower people with digital skills, such as the Good Things Foundation (https://www.goodthingsfoundation.org/fix-the-digital-divide/)

- Co-produce effective equity and inclusion policies and practice guidelines for digital interventions at a local service level in collaboration with people that have lived experience of receiving them (as a service user or their significant other).

<u>For workforces in services using digital interventions</u>

- To design mental health care for everyone we need to develop a workforce at all levels (including leadership positions), that more closely represents the local population and communities (O'Brien et al., 2022) and includes people in decision making on the development of digital practice.

- To embed anti-oppressive practice into the development of workforces, which includes taking active steps to dismantle policies and processes that perpetuate discrimination against staff from minoritised backgrounds. For example, actively seek to understand and dismantle organisational barriers to uptake to training opportunities and/or leadership roles around digital engagement work, for example progression routes and recruitment processes.

- Reflect on the barriers to uptake of digital mental health interventions across the workforce and take affirmative action to address the barriers. Provide staff with the necessary resources, training, supervision, and line management to enable effective and safe digital practice, helping staff to recognise the skills they already have and how these can be transferred to digital work.

- Staff from minoritised groups having equal opportunities for access to training, which is sensitive and responsive to the varying learning needs, values, and perspectives staff may hold in relation to the development of digital practice.

- Invest **in** the conditions required to build psychologically safe work cultures. More specifically, highlight those that regularly review the governance and equality and diversity policies include reviewing access to online interventions.

- The need for staff to have reflective space and training, for example in England concerning the current transformation of the Health and Social Care system and the ambitions of the Long Term Plan (NHS, 2019) in relation to health inequalities and also the implementation of trauma informed digital practice.

<u>For commissioning of services and policy making</u>

- Provide adequate funding and resource for co-produced partnership working. Co-production is integral to trauma informed care and vital to the development and provision of excellence in inclusive service provision. The Working Well Together document provides tools and evidence to enable co-production in commissioning https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/working-well-together/working-well-together---evidence-and-tools-to-enable-co-production-in-mental-health-commissioning.pdf?sfvrsn=4e2924c1_2

- Co-develop outcomes and evaluation methods with those that have received digital interventions, particularly individuals from minoritised groups (O'Brien et al., 2022).

- Develop core policies, strategies and objectives, which recognise structural barriers to equity and agree how the service will achieve equity of access specifically for online interventions.

- Encourage innovative practice to build the evidence base for more diverse interventions, ensuring dedicated funding and policy.

- Understand the interface between face-to-face interventions and digital practice, ensuring these work together in harmony and facilitating each other.

<u>For the DCP Digital Health Sub-committee</u>

- Consistently and meaningfully co-produce a national digital strategy for Clinical Psychology including, training and co-production of policy with individuals from communities that digital interventions are trying to reach.
- Actively developing and maintaining connection between communities and the DCP committee.

- Promote the need for large scale and localised research to understand the accessibility to and impact of digital interventions, particularly for groups known to be excluded from services, alongside communities for example using participatory action research approaches (Graham, McCuthcheon, Kothari, 2019; Pratt, 2020). Seek to develop connections between researchers who are exploring equality and inclusion in relation to digital practice and synthesise findings.

- Encouraging continued development of digital practice policies, which impacts service development to be from the ground up.

- Developing a committee that represents the population of whom digital interventions are reaching.

Good practice examples

Several projects have been or are being conducted which highlight the DCP Digital Healthcare Subcommittee's recommendations in terms of promoting inclusive digital practice in mental health. Below are three examples:

<u>Research:</u>

In recent years, several online mental health interventions have been developed that aim to improve engagement and treatment outcomes for individuals with psychosis, including virtual reality, web-based, and mobile app programs (Alvarez-Jimenez et al., 2014; Garety et al., 2021; Freeman et al., 2022). Online interventions have the potential to be cost-effective, more compelling and engaging, and provide opportunities for the collection of real-time data and effective tailoring of exposure-based exercises for people with psychosis (Rus-Calafell & Schneider, 2020). However, it is important to consider that People of the Global Majority (PoGM) and individuals experiencing economic hardship are at greater risk of both developing psychosis and being digitally excluded (Ennis et al., 2012). Several barriers to uptake of technologies have been identified in the literature, including concerns about data protection and privacy, individuals not having access to appropriate devices, or a confidential space at home from which to engage with interventions (Bucci et al., 2018; Watson et al., 2021).

SlowMo is an eight-session cognitive-behavioural intervention supplemented by a website and mobile app, which encourage users to notice 'fast thinking' habits that can contribute to paranoia, slow down their thinking, and identify safer thoughts (Garety et al., 2021). A strength of the intervention is the centrality of co-production and inclusivity in the design and evaluation of the product. The SlowMo Patient and Public Involvement (PPI) team included peer researchers who were typically underrepresented in psychological intervention research. They contributed to the qualitative data collection and analysis (Hardy et al., 2018). The research team found that technology use and confidence was lower in Black people and older people, however that this did not impact upon engagement with SlowMo, suggesting that the therapy was inclusive in its design (Hardy et al., 2022). The authors note that many digital mental health

technologies fail to be implemented into routine clinical care even after showing efficacy in clinical trials, highlighting the importance of tailoring interventions to meet the needs of diverse client groups, and evaluating the effectiveness of such interventions in bridging the digital divide.

Healthcare sector*:*

Despite the rapid uptake of digital technologies within NHS services during the COVID-19 pandemic, around 7% of people in the UK are non-internet users (Lloyds Bank, 2020), and people with mental health problems are at heightened risk of digital exclusion (Greer et al., 2019). Furthermore, in a recent NHS Providers survey, approximately a quarter of respondents felt confident in their board's arrangements to tackle digital exclusion (NHS Providers, 2022). Central and North West London (CNWL) NHS Foundation Trust launched their Digital Empowerment and Inclusion Project during the pandemic, which provided digital devices and relevant training to service users who needed them, enabling them to remotely access mental health support and keep in touch with friends and family members whilst accessing CNWL services (CNWL, 2022). Service users and clinicians worked collaboratively to identify required applications, with the Digital Inclusion Team building and configuring devices before dispatching them to services, offering training and follow-up sessions to both staff and service users. The project has enabled more effective identification of those who are digitally excluded, by allowing clinicians to capture data on digital exclusion in electronic record systems. Evaluation of the project is ongoing; however, it has been positively received by both staff and service users. The project highlights the benefits of NHS services taking an active role in identifying digital needs in their local area, offering tangible ways of addressing exclusion, and supporting both employees and users of services to engage with person-centered digital care.

Voluntary, Charity and Special Enterprise Sector:

In 2016, Reboot UK was launched by the Good Things Foundation in collaboration with Family Fund, Mind, and Homeless Link, offering targeted interventions to families in poverty, people with mental health issues, and homeless people to improve digital skills (Good Things Foundation, 2017). Following a review of relevant literature and conducting focus groups and interviews with delivery partners and beneficiaries, three core interventions were developed. This included training peer mentors to offer informal support and advice and digital skills training with the aim of creating a non-hierarchical learning environment, and setting up referral pathways between existing mental health services and digital skills organisations, with an emphasis on outreach. In addition, home access projects were implemented involving the loaning and granting of IT equipment supplemented by one-to-one and group training. The evaluation of the project identified that learners increased their digital skills on average by 14.6% and felt 17% more confident when using the internet, with improvements in mental wellbeing observed. There were challenges identified with the resource intensiveness of providing home access to digital devices, making this aspect of the project difficult to upscale.

Overall, the project underscores the value of offering tailored support and teaching practices to those facing multiple disadvantage, facilitating the development of digital learning communities, partnership with organisations to cater to local need, and prioritising outreach and engagement work when addressing the digital divide.

Conclusions

The current context is one of rapid development both in the development, evaluation and provision of online interventions. The use of online interventions has enabled many people to access services that they otherwise might not have been able to access. However, there is a need to focus on the growing divide that exists between those who can and those who cannot access online healthcare. To acknowledge the inequity and discrimination experienced by minoritised groups and to take steps to ensure the intersection of the multiple disadvantages and discrimination people can experience is considered and responded to comprehensively. We consider the co-production between staff (commissioners and providers), service users, significant others and wider communities to be key to achieving this.

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