Letters

A response to Louise Stone and Russell Waldron's article

Louise Stone and Russell Waldron's article '*Great Expectations* and e-mental health: The role of literacy in mediating access to mental healthcare' (*AJGP* July 2019)[1] puts forward the case that low literacy may limit the reach of e-health programs and thus fail to reach those most in need.

We agree. There is no doubt that many of these 'first generation' programs were designed for people with higher education, and research papers have shown that people who were more educated responded better. Adherence can also be low, although this is a common problem in all psychotherapies including those with the best therapists in face-to-face contact.

Since these programs were developed, we have learnt a lot – including the critical need for co-design and the recognition that e-health programs have to meet the needs of those who wish to use them. Two recent examples of 'second generation' e-health programs include iBobbly and Healthy Mind. iBobbly, designed with Aboriginal and Torres Strait Islander young people, uses metaphors and Aboriginal and Torres Strait Islander voices, is accessible without internet, has resulted in reductions in anxiety and depression in users in the Kimberley, and also shows incredible adherence rates. Healthy Mind is a mental health app specially tailored for individuals with borderline-to-mild intellectual disabilities, a varied condition that affects approximately 3% of Australians, making it the nation's most common primary disability. A revolutionary digital project, Healthy Mind is the first app of its kind in the world. It will be made available to any Australian living with an intellectual disability. Both of these e-health programs have been designed by the Black Dog Institute. The OnTrack programs were written with a maximum of a Year 7 reading level (www.ontrack.org.au/site/), and the ThisWayUp courses use comic-based slides, which have been developed and continually refined together with end-users to make them engaging and readable.

The aspect of the article that we do not agree with is the analogy that e-mental health services represent wire monkeys. E-health products are effective. By analogy, would we wish to argue that antidepressant medications are wire monkeys? Moreover, the wire monkey mothers were harmful to young vulnerable monkeys provided with nothing else. Both medications and e-health help are highly effective for anxiety, depression and suicide ideation in many patients. Beyond efficacy, data also show that e-health programs can effectively build therapeutic alliance. The analogy just does not work!

We could not agree more that literacy, culture, personality, gender and indeed many factors need to be considered into the future in the design of e-health products. However, the argument that e-health perpetuates a culture of disadvantage is not sustainable, and indeed it runs counter to much of the work (not discussed in the article) that is now undertaken in this area.

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Reply

Thank you for your thoughtful comments on our article '*Great Expectations* and e-mental health'.[1]

We recognise that e-mental health (eMH) is a tempting solution to the vexed problem of lack of access to services due to cost or geographical isolation.[2] The *Fifth National Mental Health and Suicide Prevention Plan* envisions a health system that 'ensures that all Australians with a mental illness can access effective and appropriate treatment and community support'.[3] At present, disadvantaged patients access care far less frequently than the general population.[4]

However, we believe that every intervention – including medications, devices or therapeutic techniques – will have benefits, potential side effects, indications and contraindications. Simply put, we think eMH programs are contraindicated if they cannot be 'ingested' because of low literacy. It is

undoubtedly challenging to represent a complex and layered experience such as mental health in text. The iBobbly team are to be commended for engaging the local community in a co-designed product, and we look forward to further research in this area. But there may well be populations that cannot be reached by eMH programs.

We should also not ignore the ample evidence for the effectiveness of therapeutic relationships in mental healthcare. Baby monkeys in Harlow's wire monkey experiments were fed but denied an attachment relationship: the equivalent of receiving techniques without a therapeutic relationship. We need to consider the impact of relationships in eMH research; many studies depend on them as part of co-design, through therapeutic engagement or researcher support. We need to understand the role of these attachments to decide whether an eMH program is evidence based with or without a relationship component.

So we agree there is a strong evidence base for eMH. However, that evidence base is only strong for patients with depression and anxiety, above-average literacy and no significant comorbidities, who are aged <65 years and have access to digital devices. Unfortunately, this is not the group most in need of services. If eMH is to be the solution to the significant treatment gap experienced by disadvantaged populations, we need to generate evidence in disadvantaged communities. Until then, we need to be cautious about overgeneralising the existing evidence.

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