

Digital Inclusion and Access to Mental Health Services



Reducing barriers and leveraging
the positive potential

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Executive Summary

This report examines the crucial issue of digital inclusion and its impact on access to mental health services in Ireland. With the increasing use of online and digital platforms in delivering mental health services, it is essential to examine the challenges and opportunities this presents.

The report provides the first detailed examination of digital mental health inclusion in the Irish context. It offers a timely contribution to the discussion, ensuring that everyone has fair and equal access to mental health resources in an increasingly digital world. By exploring the intersection of digital inclusion and equality of access to mental health services, the report brings attention to the challenges faced by specific groups and provides insights into addressing these disparities. It provides detailed insights and guidance for the mental health sector and other stakeholders with key roles in progressing the digital mental health inclusion agenda.

Conducted by Mental Health Reform with funding from HSE's Mental Health Engagement and Recovery Office, the study was a substantial piece of work involving both desk research and field work. Desk research included collation of available Irish data on digital divides and mental health inequalities and review of digital mental health inclusion initiatives from Ireland and other countries. Field work involved an online survey of seventy-six mental health practitioners and in-depth interviews with fifteen organisations working with a range of disadvantaged or otherwise vulnerable groups.

Digital mental health & digital mental health inclusion

Digital mental health refers to technology-enabled provision of mental health services and supports. Even prior to the COVID-19 pandemic, digital channels were already becoming an established feature of the mental health ecosystem for activities such as online information, psychoeducation and sign-posting; online Cognitive Behavioural Therapy (CBT) programmes; and mental health apps. The pandemic restrictions then prompted a massive shift to remote provision of client-therapist sessions via video calls and other channels. Even with the re-introduction of face-to-face services as the pandemic recedes, remote therapy provision and other online and digital approaches will remain an important component of the mental healthcare system.

Digital inclusion and access to mental health services

The use of digital mental health technologies brings numerous benefits, including increased flexibility and the potential for innovative service delivery. However, certain population groups may face disadvantages in this post-pandemic 'new normal' if their needs are not addressed.

Digital mental health inclusion encompasses two dimensions. Firstly, it involves addressing the barriers and inequalities that create a "digital divide," preventing disadvantaged groups from accessing digital mental health services. Secondly, it involves purposefully leveraging the positive opportunities presented by digital mental health to reach and support groups that are currently underserved or hard-to-reach by traditional mental health services. Both are important areas for attention by the mental health sector, whilst also ensuring that more traditional face-to-face options remain available and digital does not become the only option.

Intersectionality - digital inclusion as a social determinant of health

Intersectionality between the broader digital inclusion agenda and efforts to reduce prevailing mental health inequalities is an important theme running through the report, as is the increasing recognition of digital inclusion as a social determinant of health (physical and mental). Therefore, as well as an issue requiring attention by the mental health sector itself, digital mental health inclusion also falls within the scope of wider programmes such as the Department of Public Expenditure NDP Delivery and Reform's 'Digital for Good: Ireland's Digital Inclusion Roadmap'.

Population level picture

The report begins by setting the scene at the population level in Ireland, looking at patterns across some of the main socio-economic and socio-demographic group breakdowns provided in large-scale national surveys. Available data shows the existence of both mental health inequalities and digital divides, with strong overlap between the groups affected by each. This means that these groups are likely to be at risk of experiencing digital mental health divides as well.

Mental health inequalities

Nationally representative surveys such as the Irish Health Survey show substantially greater prevalence of mental health difficulties amongst more disadvantaged socio-economic groups as well as significant under-utilisation of mental health services relative to prevalence of need. These datasets also show substantial under-utilisation of mental health services relative to need amongst older age groups, and data from the TILDA study for the 50+ age groups show much higher prevalence of mental health difficulties amongst less advantaged older people and those with vision or hearing impairment.

Digital divides

Data from CSO and Comreg surveys provide a range of evidence on digital divides in Ireland today. The most obvious is that many older people do not use the internet, with this the case for almost one-half of those aged 75 or older. Available data also shows lower digital literacy/skills amongst older people and disadvantaged groups. Access to fixed home broadband is still an issue for substantial numbers of households, with more than one-in-seven not having this connectivity. Apart from those affected because of rurality, groups less likely to be connected include older persons and more disadvantaged socio-economic groupings. Mobile access can provide an alternative for some people, although affordability of mobile data charges may be a barrier for more disadvantaged groups to use services that consume a lot of data. Additionally, quite substantial numbers of people do not have a smartphone, including just over one-in-three of those aged 65 or over. Reliance on a smartphone may also be a disadvantage for using applications where a larger screen device would be preferable, and likelihood of having such a device decreases amongst more disadvantaged socio-economic groups.

‘Double jeopardy’

Groups experiencing both mental health inequalities and digital divide barriers are at a particular disadvantage regarding access to digital mental health and to the benefits this can offer. The evidence summarized above suggests that substantial numbers of people are now at risk of this ‘double jeopardy’. Despite the absence of dedicated surveys of digital mental health usage patterns in Ireland, evidence of digital mental health divides is already becoming apparent in various ways. For example, older people and more disadvantaged socio-economic groups are less likely than other groups to search online to seek health information. Data on utilization of publicly-funded online CBT programmes in Ireland also show substantial under-representation of older age groups.

Practitioner and user organisation perspectives

Seventy-six mental health practitioners (mostly counsellors/psychotherapists) completed an online survey about their experiences of digital inclusion issues in their work with clients. Respondents were mainly working either in the private or non-profit sectors and a small number worked in the public sector. Almost all practitioners reported having at least some remote consultations with clients/service users by videocall during the pandemic and a large majority plan to offer both remote and face-to-face options going forward. However, many practitioners already see digital divide factors and other disadvantages posing difficulties for some client/service user groups they work with to avail of remote consultation options, with this more likely amongst practitioners in the non-profit sector.

Consultations with fifteen organisations working with a range of disadvantaged or otherwise vulnerable groups identified substantial digital divide barriers arising from general socio-economic disadvantage. Measures addressing access to devices, connectivity, affordability, and digital literacy/skills are therefore important. More specific barriers faced by the various groups include lack of accessibility of digital mental health services for people with disabilities, language barriers, and challenges that aspects of mental health difficulties may pose for usage of digital mental health services. On the other hand, logistical and other features of digital mental health provide many positive opportunities to better reach these groups with mental health services they need.

Illustrative listing of opportunities presented by digital mental health

Specific group	Opportunity area that could be leveraged to improve access to mental health services
Migrants and refugees	<ul style="list-style-type: none"> Nationwide access to culturally competent practitioners/services, range of languages. In-reach opportunities to provide more specialist services (e.g., trauma therapy). Reduce barriers to accessing local mental health services because of transport issues.
Travellers	<ul style="list-style-type: none"> Nationwide access to Traveller-specific and culturally appropriate mental health services. Anonymity and self-directed nature may reduce concerns around discrimination. 24/7 or 'out of hours' aspect of online/digital options may be helpful for those in crisis.
Prisoners	<ul style="list-style-type: none"> Potential to open up access to community-based services available to general pop. Support continuity of care before/during/after prison. Dedicated mental health and substance abuse support services for people on probation.
Blind / vision impaired	<ul style="list-style-type: none"> Avoid challenges they may experience with transportation and navigation. Access to mental health services specifically targeting people with vision impairments. Accessible design and assistive technologies to make MH supports more available.
Deaf / hard of hearing	<ul style="list-style-type: none"> Videoconferencing a familiar mode of communication amongst Deaf community Text-based supports/resources may be accessible for range of hearing abilities. Potential for accessible design and assistive technologies to alleviate barriers. Opportunities presented by video-relay and remote sign language interpreter services.
Homeless	<ul style="list-style-type: none"> Logistical flexibilities may facilitate access for people without stable accommodation and open new opportunities for mental health services to reach this underserved population. Digital tools for screening for prevalent mental health difficulties. Specialist in-reach to support frontline MH services (e.g., through telepsychiatry).
Older people	<ul style="list-style-type: none"> Logistical benefits for older people in rural areas and/or who have reduced mobility Video consultation from home may open new opportunities to address the substantial unmet need for mental health supports amongst older people. Enables increased access to specialist supports (psychiatry of later life, dementia, etc.).
Younger people	<ul style="list-style-type: none"> Generation of 'digital natives' – online/digital channels familiar mode of communication. Many new opportunities to reach young people where they are at. Way of building rapport and trust with hard-to-reach/disengaged young people & facilitate access for young people/families not typically attending in person services.
People with ongoing / enduring MH difficulties	<ul style="list-style-type: none"> Logistical and other flexibilities offer transformative potential in this domain. Remote consultations may enable improved continuity of care. Can support greater involvement in own care (e.g. access to care plans, crisis plans or electronic health records), empower individuals, support self-management. Facilitate access to peer support including online support groups, forums, etc.

Opportunity areas include providing access from home for people with mobility or transport problems, remote in-reach services to congregate settings, and provision of nationwide access to culturally competent practitioners and services in a range of languages. Provision of increased access to specialist services targeting particular needs groups is another important opportunity area, for example, for people with sensory disabilities, refugees with severe trauma histories, and groups such as Travellers that experience higher risk of mental health crises and suicidality. The logistical and other flexibilities offered by digital mental health also present important opportunities to better support people with severe and enduring mental health difficulties through more continuity of care and empowering self-management and recovery.

Sectoral roles and responsibilities in addressing digital mental health inclusion

Based on the evidence from the various strands of the research, the report then provides an analysis of sectoral roles and responsibilities in addressing digital mental health inclusion. This examines what actions may appropriately fall within the remit of the mental health sector itself as well as giving some attention to ways other sectors such as the telecoms industry and broader social/digital inclusion sector can play a role in this domain. To support this analysis, the report identifies and discusses a range of initiatives already implemented in Ireland and internationally by these stakeholders.

The sectoral analysis focuses on four areas of action to reduce barriers to digital mental health inclusion: ensuring users have the practical pre-requisites for access (devices, connectivity, affordability); promoting user skills, literacy and motivation; designing digital mental health services and tools to be inclusive; and multi-modal access to mental health services and supports, including non-digital options.

In examining the mental health sector's role and scope for action in addressing these themes, it is useful to consider different contexts of mental health service usage: universal, target group, and individual client-provider relationships. The analysis suggests that, at all these levels, the mental health sector has strong responsibilities for inclusive design and maintaining availability of non-digital options/channels as well for developing user mental health (and digital mental health) literacy and skills. At the target group and individual client-provider relationship levels, the mental health system and service providers may also have a role in supporting disadvantaged clients with access to devices, connectivity and usage charges in situations where digital mental health is an important component of the relevant mental health support.

Recommendations

The report offers several recommendations for action based on the evidence and analysis presented. These recommendations aim to progress the digital mental health inclusion agenda by reducing barriers and leveraging positive opportunities. The key issues addressed include access to and affordability of devices and connectivity, user literacy and skills, and inclusive design of services. Many of the recommendations are addressed to the 'mental health sector', which encompasses the Department of Health, HSE and other statutory agencies, and voluntary and community sector mental health organisations.

Recommendations

1. Department of Health, HSE and mental health policy implementation processes to give digital mental health inclusion high visibility and importance in current and forthcoming strategies.
2. Department of Health to engage with other Departments and agencies on measures to address access to and affordability of digital mental health as an important category of online/digital public services.
3. Mental Health Sector, within its own remit and scope of action, to develop approaches to address digital divide barriers for relevant mental health service users and usage contexts.
4. Mental Health Sector to develop a line of action within a social-inclusion/inclusion-health framework to leverage digital mental health to reach and support vulnerable groups.
5. Mental Health Sector to directly engage with mental health service users on their experience of digital mental health inclusion and involve them in developing solutions and service co-design.
6. Mental Health Sector and Adult Literacy Sector to work together to develop and implement a large-scale programme combining digital skills and mental health literacy.
7. Government to provide funding for 'bottom-up' digital mental health inclusion and innovation projects under Digital for Good or other relevant frameworks or funding mechanisms.
8. Mental Health Sector to give focused attention to accessibility of online/digital mental health for people with disabilities.

1. Department of Health, HSE and mental health policy implementation processes to give digital mental health inclusion high visibility and importance in current and forthcoming strategies

The evidence and analysis in this report indicate that digital mental health inclusion is an important topic for attention at strategic levels of policy and action. Department of Health, HSE and mental health policy implementation processes should give it high visibility and importance in current and forthcoming strategy on digital health, digital mental health and mental health more generally. Some key immediate contexts for this include the forthcoming Digital Healthcare Strategic Framework 2023-2030 and the Digital Mental Health Strategy under development in the context of implementation of Sharing the Vision mental health policy.

2. Department of Health to engage with other Departments and agencies on measures to address access to and affordability of digital mental health as an important category of online/digital public services

Digital inclusion is now recognized as an increasingly important social determinant of health. This needs highlighting for attention under programmes such as Digital for Good, with particular attention on measures targeted to address access and affordability for low-income groups. The Department of Health could take the lead on this and engage with other relevant Departments and agencies. The report presents examples of publicly funded approaches from other jurisdictions showing what can be done in this area.

One measure is public financial support towards the costs of broadband connectivity and devices for eligible persons or households. An example is the 'Affordable Connectivity Program' in the United States which provides discounts towards monthly internet service costs as well as a one-time discount for purchase of a laptop, desktop computer or tablet.

Another measure is to 'zero-rate' connectivity charges for utilization of designated websites or services. During the early phase of the pandemic in Ireland, ComReg announced an initiative with telecoms operators to zero-rate customer telecoms costs for usage of healthcare and educational resource websites identified by the Government. The measure also indicated customers and people without fixed broadband and dependent on mobile access would have an opportunity to avail of affordable unlimited mobile data access/package from their service provider. Currently, a number of countries have zero-rating approaches where costs are charged to the health system, including the 'Sponsored Data' programme in New Zealand and the Veterans Health Administration's 'Mobile Connectivity Support for Telehealth' programme in the United States.

Another potentially relevant approach is the long-established 'rural healthcare programme' in the United States. This includes measures such as the 'Healthcare Connect Fund' providing substantial discounts for connectivity costs for eligible rural healthcare providers.

3. Mental Health Sector, within its own remit and scope of action, to develop approaches to address digital divide barriers for relevant mental health service users and usage contexts

As well as the broader inter-sectoral approaches discussed under Recommendation 2, the analysis indicates the mental health sector should also consider, within its own remit, development of approaches to address digital divide barriers arising for relevant mental health service users and usage contexts. This might be especially relevant to enable access to digital mental health services, where indicated, for service users having a direct 'patient' or 'client' relationship with mental health services, for example, for a once-off programme of therapy sessions and/or for longer term and more episodic relationships.

The report identifies a number of local initiatives in this area by public and non-profit mental health services in England. Some examples have also been emerging in Ireland, including a currently fairly small-scale initiative within the HSE that makes SIM-enabled tablets available for frontline services to loan to clients to enable remote access to indicated clinical care. Internationally, the largest initiative in this area is probably the Veterans Health Administration 'Internet-Connected Devices' programme in the United

States which provides an internet-connected device to relevant clients so they can utilize telehealth services. This programme commenced in 2016 and is extensively utilized for access to telemental health services. Evidence indicates positive impacts through increased mental health care access, continuity and efficiency.

Given the emerging evidence of the benefits accruing for both mental health service users and providers, HSE should consider scaling up provision of devices and connectivity for relevant clients. It should also engage with voluntary and community sector mental health organisations on how they can be supported in this area, for example, through drawdown from HSE stocks and/or through funding streams to enable them to have their own stocks. In addition to devices and connectivity, mental health service users may require technical support to get set up and learn how to use the intended digital mental health service(s). The report presents some existing Irish examples of mental health services providing these forms of tech support themselves. Another approach is to build in this tech support as part of an IT supplier's contract, such as in the arrangements between HSE and its video consultation platform providers.

4. Mental Health Sector to develop a line of action within a social-inclusion/inclusion-health framework to leverage digital mental health to reach and support vulnerable groups

As well as the importance of reducing barriers arising from digital divide factors, digital mental health inclusion also opens many possibilities to leverage its positive potential to provide effective solutions for under-served and hard-to-reach groups. Voluntary and community sector organisations working with a range of vulnerable groups identified a wide variety of ways the logistical and other features of digital mental health can contribute to addressing unmet mental health needs. More generally, a number of recommendations in *Sharing the Vision* focus on enhancing mental health services for vulnerable groups, and digital mental health initiatives offer considerable opportunities to support their achievement.

HSE can make a major contribution in this area through its in-house inclusion health and social inclusion frameworks as well as through its funding mechanisms for the voluntary and community sector. Similar to Recommendation 3 above on reducing barriers, scaling up provision of devices and connectivity for relevant clients would be very helpful in supporting service innovation in this area.

Whilst digital mental health opens major opportunities for innovation in this field and can help fast-track provision of services that might otherwise be very slow to develop and implement, efforts to enhance face-to-face access to services should also be kept to the fore. Multi-channel or hybrid models combining digital and face-to-face in flexible ways can provide choice and ensure face-to-face options are not eroded or sidelined because of an over-emphasis on online/digital approaches.

5. Mental Health Sector to directly engage with mental health service users on their experience of digital mental health inclusion and involve them in developing solutions and service co-design

The current study provides compelling evidence on the importance of the digital mental health inclusion issue from a variety of sources and perspectives. While this study involved some engagement with mental health service users on their experiences in this area, it did not have scope for substantial direct engagement across a range of user groups or situations. More generally, the available literature and evidence is very limited in this regard.

The mental health sector should develop a programme of activity in this area, utilizing existing user engagement mechanisms and/or new channels of consultation as required. The programme would directly engage in various ways with mental health service users on their experience of digital mental health inclusion barriers and opportunities and involve them in developing solutions. This could include both larger scale representative surveys and more in-depth consultations with particular user groups, as well as establishment of mechanisms for user involvement in digital mental health service co-design. HSE Mental Health Engagement and Recovery might be well placed to take the initial lead on this and develop the necessary collaborations with user organisations, other HSE functions and the voluntary and community sector to progress the programme.

6. Mental Health Sector and Adult Literacy Sector to work together to develop and implement a large-scale programme combining digital skills and mental health literacy

From the user perspective, likelihood of availing of digital mental health opportunities requires not just access to devices and connectivity but also awareness of what's on offer and the motivation and skills to find and use relevant online/digital services. Digital literacy and mental health literacy are both relevant here, and significant opportunities arise to address these together in a coordinated manner. Actions in this area fall within remits of both the mental health sector and the adult education sector.

The mental health sector has an important role to play in population mental health promotion. One core line of action is through development and funding of psycho-educational programmes, either directly provided by HSE or supported through funding voluntary and community sector organisations to address this area. These approaches can help increase general mental health literacy as well as digital mental health literacy. However, for reasons of efficiency and scale, they increasingly rely on online delivery channels and so are unlikely to effectively reach those affected by digital divide barriers. More generally, motivational factors may limit the participation of many disadvantaged or otherwise vulnerable groups even if they have the possibility to connect.

Through the National Adult Literacy Agency (NALA), the adult literacy sector has been expanding its remit beyond the traditional focus on reading and arithmetic to encompass new themes emerging with societal change and trends. This includes attention to digital literacy and also to health literacy. A joint HSE and NALA programme to develop a major digital inclusion skills development programme combining digital literacy, mental health literacy and digital mental health literacy modules might be a very effective approach in this field. The branding and configuration of modules could be tailored to different delivery contexts - digital skills programmes could include mental health literacy and digital mental health literacy as application-oriented components of courses; and mental health literacy programmes could include digital and digital mental health skills as ways for participants to put mental health literacy into action.

For hard-to-reach groups, the novelty factor of digital mental health and the possibilities to address mental health within the context of broader programmes around digital inclusion could prove effective for engaging people on mental health issues in the first instance. This initial engagement might then progress to more self-help with mental health issues (whether through traditional or digital resources and tools) and increased utilization of mental health services to address unmet needs (again, whether through traditional or digital modes of service access).

7. Government to provide funding for 'bottom-up' digital mental health inclusion and innovation projects under Digital for Good or other relevant frameworks or funding mechanisms

In addition to the recommendations mentioned above, it is important to allocate funding to encourage and support "bottom-up" initiatives focusing on digital mental health inclusion and innovation. Provision of a substantial digital mental health inclusion fund seeking calls for proposals from relevant user groups and organisations working with them would provide a framework to promote innovation and collaboration to reach underserved groups through digital mental health. An effective way to do this might be through cross-departmental funding (from Departments of Health, Communications, Community Development, and others) for a programme on this topic under Digital for Good or via other relevant funding frameworks or mechanisms. The Sláintecare funding programmes for community/integrated care pilot projects may provide a useful model in this regard.

Such a fund could be open to actions that address particular pre-specified issues as well as provide more open-ended opportunities for stakeholders to develop ideas and pitch for them. Setting overall aggregate impact targets for the programme might help provide coherence and ensure value for money. For example, such a fund could aim to reach a target number of people through provision of digital mental health interventions and/or enabling them to benefit from digital mental health supports as required. Funded projects would each establish their own targets in this regard, commensurate with their scale and ambition.

To provide a more concrete illustration, a suggested approach could involve allocating a relatively modest but ambitious fund of €5 million. This fund would aim to have an overall reach of 20,000+ individual beneficiaries. The fund would support a range of initiatives and projects focused on digital mental health inclusion and innovation, targeting underserved populations and addressing the specific barriers they face.

8. Mental Health Sector to give focused attention to accessibility of online/digital mental health for people with disabilities

Disability organisations consulted for this study identified a range of accessibility barriers that can exclude people with disabilities from utilizing digital mental health services. These include basic web accessibility barriers that have still not been addressed on mental health websites as well as new issues emerging with the increased provision of remote access to interactive mental health services and supports through video consultation platforms and other channels. The report provides examples of significant issues arising for a number of disability groups, including people with vision or hearing impairments.

HSE, voluntary and community sector organisations, and private mental health service providers should all give focused attention to this issue. They should ensure familiarity with, and implement, relevant national and international standards and guidance on online/digital accessibility. This includes general web accessibility requirements as well as emerging guidance on telehealth and other relevant themes (e.g., the recent WHO/ITU guidance mentioned in the report). In line with UNCRPD requirements, equally important would be to consult and engage with Disabled Persons Organisations and users with lived experience and expertise in this domain. They are uniquely placed to provide guidance on accessibility issues in this dynamically evolving field of applications and delivery platforms.



Introduction



1 Introduction

This report examines digital inclusion issues affecting access to mental health services in Ireland, an important topic for attention now that online/digital channels are increasingly utilized in delivery of mental health services. Mental Health Reform prepared the report with funding from HSE's Mental Health Engagement and Recovery Office.

The report presents the first detailed examination of digital mental health inclusion issues in the Irish context and provides a timely and important contribution to ensure that all individuals have equitable access to mental health resources in an increasingly digital world. By exploring the intersection of digital inclusion and equality of access to mental health services, the report aims to shed light on the challenges faced by specific groups and provide insights into addressing these disparities. It provides detailed insights and guidance for the mental health sector and other stakeholders with key roles in progressing the digital mental health inclusion agenda.

A recent publication from the National Economic and Social Council (NESCC) identifies digital inclusion as an important issue for focused and ongoing attention to ensure equality of access to benefits of the information society (NESCC, 2021). One of the NESCC recommendations was to develop deeper understanding of the issues for specific groups that may be especially vulnerable to inequalities in this regard. The current report addresses this through its analysis of the role of digital inclusion in efforts to ensure equality across the population in opportunities to access mental health services and supports. As well as an issue requiring attention by the mental health sector itself, the topic also falls within the scope of wider programmes such as the Department of Public Expenditure NDP Delivery and Reform's 'Digital for Good: Ireland's Digital Inclusion Roadmap' (DPENDR, 2023).

Digital mental health & digital mental health inclusion

Digital mental health refers to technology-enabled provision of mental health services and supports. Before the COVID-19 pandemic, digital channels were already becoming an established feature of the mental health ecosystem for activities such as online information, psychoeducation and sign-posting; online Cognitive Behavioural Therapy (CBT) programmes; and mental health apps. The pandemic restrictions then prompted a massive shift to remote provision of client-therapist sessions via video calls and other channels. Even with the return to face-to-face services as the pandemic recedes, remote and online/digital approaches will remain an important component of the mental healthcare system.

Digital mental health offers a range of logistical and other benefits, as well as possibilities for introducing more agility and other innovations in organizing and providing mental health services and supports. However, certain population groups may face disadvantages in this post-pandemic 'new normal' if their needs are not addressed. Digital mental health inclusion therefore has two dimensions. Firstly, it involves addressing the barriers and inequalities that create a "digital divide," preventing disadvantaged groups from accessing digital mental health services. Secondly, it involves purposefully leveraging the positive opportunities presented by digital mental health to reach and support groups currently underserved or hard-to-reach by traditional mental health services. Both are important areas for attention by the mental health sector, whilst also ensuring that more traditional face-to-face options remain available and digital does not become the only option.

Intersectionality between digital inclusion and mental health equality

A core theme of the report is the growing appreciation of the intersectionality between digital inclusion and mental health equality and the role of digital inclusion as a social determinant of physical and mental health (Kickbush et al, 2021). Some commentators have dubbed it a 'super' social determinant of health, impacting not just directly on the health domain but also on many of the other non-healthcare system determinants of health such as income, employment and education (Sieck et al, 2021).

Since the emergence of the internet and the increasing digitalization of daily life in the 'information society' there have been concerns about 'digital divides' and their implications. The concept of digital divide refers to some population groups having less access than others to the potential benefits of online/digital services and activities. In the research and policy domains, distinctions are sometimes made between different stages or 'orders' of digital divide. 'First order' divides concern inequalities in access because of lack of equipment

and connectivity, cost barriers, or not having the required skills. Once basic access barriers are overcome, 'second order' divides concern differences in patterns of utilization of the range of available online/digital opportunities. 'Third order' divides concern the ultimate impacts on important life outcomes that result from such inequalities.

Mental health inequalities arise through a variety of interlinked dimensions. One aspect concerns inequality in mental health status across different groups in society, for example, in prevalence of mental health difficulties or in likelihood of experiencing positive mental health. Another aspect concerns inequalities in access to and utilization of mental health services and supports, for example, because of lack of availability, costs, or attitudinal barriers. With the increasing utilisation of online/digital approaches in delivery of mental health services and supports, digital divides may introduce new forms of mental health inequalities and compound existing ones.

Research approach and methods

Although a considerable body of information is available on digital inclusion and digital divides at a general level, before this study there had been little in-depth examination of their implications within the mental health domain. The study was a substantial piece of work involving both desk research and field work. Desk research included collation of available evidence on digital divides and mental health inequalities and review of digital inclusion approaches and initiatives. Field work included a survey of mental health practitioners and a programme of consultations with voluntary and community sector mental health organisations. The relevant sections of the report provide further details on the different strands of the research and the methods employed. Data generated through the field work included responses from 76 mental health practitioners (mainly counsellors/psychotherapists) and in-depth interviews with 15 voluntary sector organisations. An earlier survey of 53 voluntary sector organisations also provided data for the analysis in this report.

Organisation of the report

The main body of the report has five Chapters. Chapter two presents the picture at population level, covering mental health need and usage patterns across different socio-economic groupings, data on digital inclusion/exclusion, and emerging evidence on digital mental health inclusion/exclusion. Chapter three presents findings from the mental health practitioners survey, providing insight on digital mental health inclusion from their vantage point. Chapter four provides a profiling of mental health issues and digital inclusion barriers and opportunities for a range of disadvantaged and vulnerable groups. Chapter five examines stakeholder roles in addressing digital mental health inclusion. Finally, Chapter 6 provides conclusions and recommendations.



The population level picture



2 The population level picture

This chapter sets the scene at the population level, looking at patterns across some of the main socio-economic and socio-demographic group breakdowns provided in large-scale national surveys. It covers mental health inequalities and digital divides, as well as digital mental health inclusion/exclusion to the extent this can be indicated from currently available data.

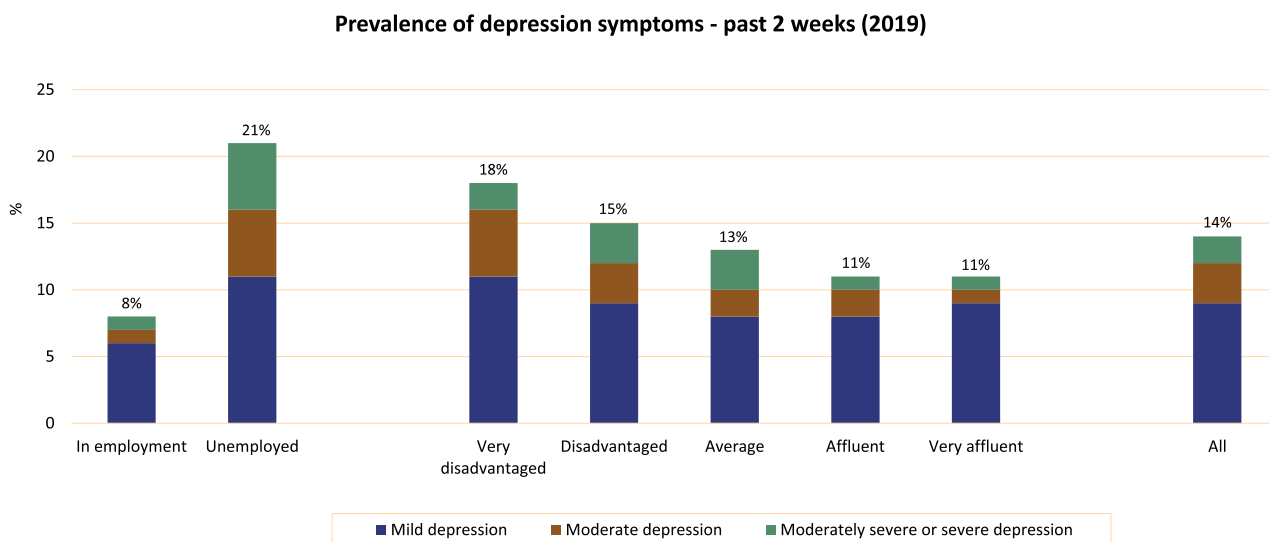
2.1 Mental health inequalities

The absence of dedicated national surveys on mental health morbidity and mental health service utilisation in Ireland limits the possibility for in-depth examination of the nature and extent of mental health inequalities. However, a number of largescale representative surveys provide a range of data on mental health status and mental health service utilization across different socio-economic and socio-demographic groups. These include the Irish Health Survey, Healthy Ireland surveys, and TILDA (for the 50+ age group). Data from these surveys mainly concerns common mental health conditions such as anxiety and depression, with an absence of data on severe/enduring mental health conditions. The surveys that address mental health service utilization do this in a fairly limited manner, without much differentiation between primary and secondary care services. Despite these limitations, sufficient data is available to show substantial mental health inequalities in prevalence of various conditions and in utilization of mental health services relative to need.

Socio-economic groups

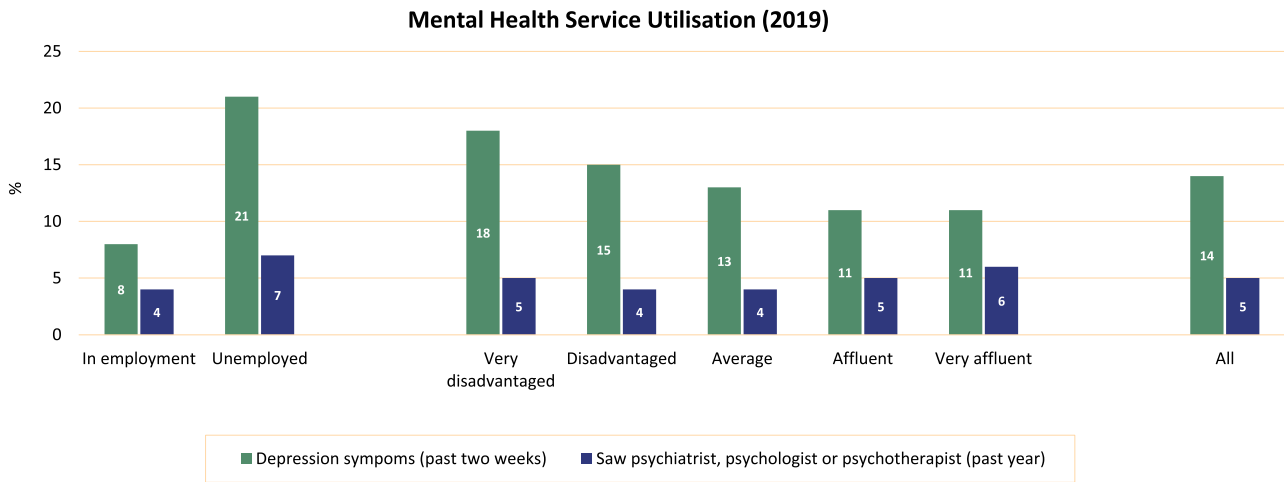
Figure 2.1 presents data from the Irish Health Survey 2019 (CSO, 2020) on prevalence of depression symptoms based on the self-report PHQ-8 instrument. This shows much higher prevalence of depression symptomatology for unemployed persons compared to those in employment as well as an inverse gradient by degree of socio-economic disadvantage, with this pattern apparent for both mild and moderate/severe depression.

Figure 2.1 Depression symptoms – Irish Health Survey (2019)



The survey also provides data on numbers of people who reported they saw a mental health professional in the past year. Although the published data does not allow direct matching at the individual level of proportions of people with depression symptoms who saw a professional, it is possible to examine patterns at socio-economic group level. Figure 2.2 shows the proportions of each socio-economic group reporting they saw a mental health professional in the past year alongside the 2-week prevalence of depression symptoms for that group. This suggests considerably less utilization relative to need for the unemployed and disadvantaged groups.

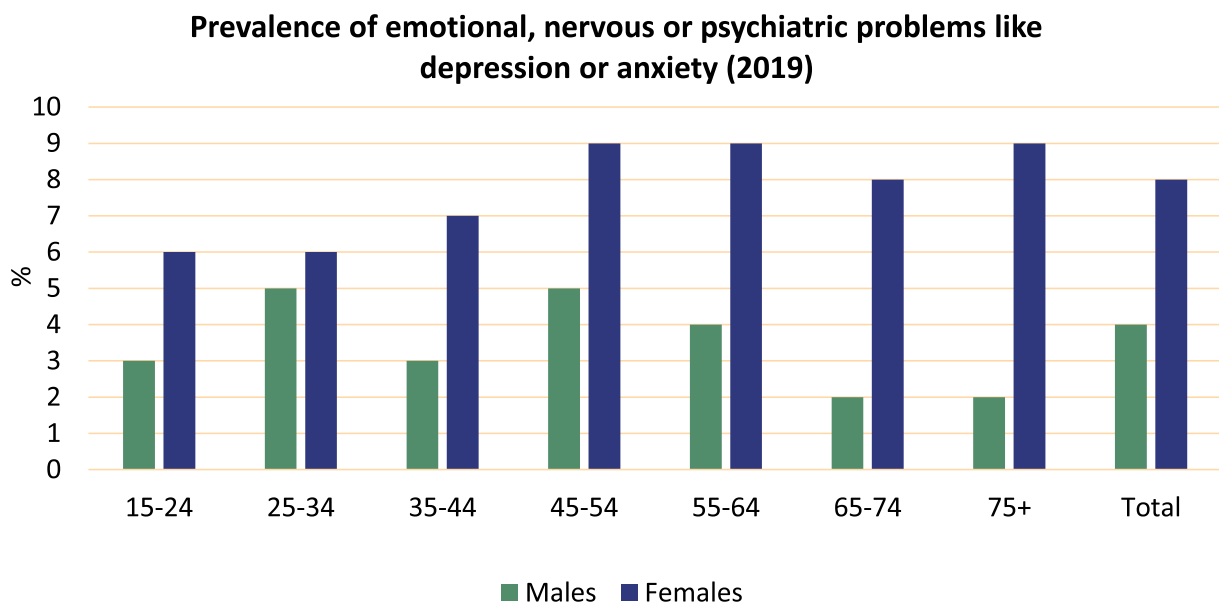
Figure 2.2 Mental health service utilization relative to need – Irish Health Survey (2019)



Gender

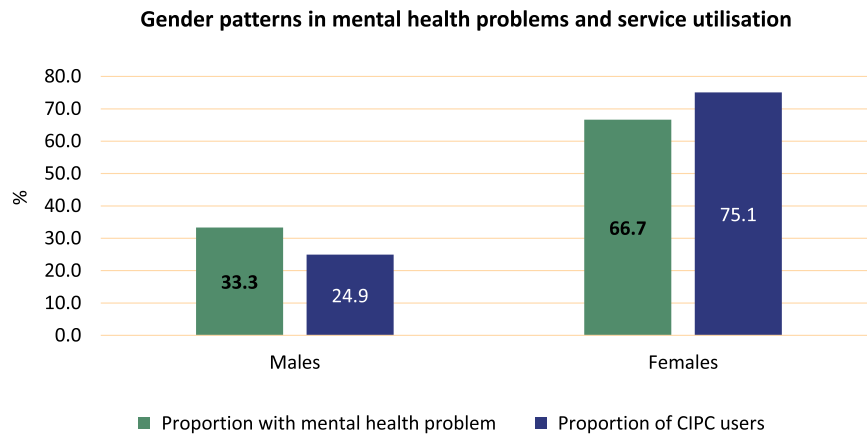
Figure 2.3 presents data from the Healthy Ireland survey of 2019, showing the considerably higher prevalence of self-reported ‘emotional, nervous or psychiatric problems like depression or anxiety’ amongst women. These patterns are similar to those found in other countries for these conditions. For other mental health difficulties, international evidence suggests higher prevalence of some conditions amongst men (e.g., autism spectrum disorder, antisocial personality disorder) and fairly similar prevalence rates amongst men and women for severe and enduring mental health difficulties such as psychoses (e.g., Adult Psychiatric Morbidity Survey 2014 from England).

Figure 2.3 Self-reported mental health problems by gender – Healthy Ireland Survey (2019)



Available data also suggests women are more likely to utilise mental health services than men, in part because of their higher prevalence of mental health difficulties but also because of a higher likelihood to seek help if they have problems. Figure 2.4 provides an illustration of this, juxtaposing the gender patterns for mental health problems from the Healthy Ireland survey and the gender profile of users of the Counselling in Primary Care (CIPC) service (CIPC, 2022).

Figure 2.4 Mental health service utilization relative to need by gender*



*Sources: Own calculations based on gender profile of people reporting mental health problems (Healthy Ireland Survey, 2019) and users of CIPC services (CIPC, 2022)

Age groups

Figure 2.5 shows data from the Healthy Ireland survey in 2019 on patterns across age groups for self-reported ‘emotional, nervous, or psychiatric problems like depression or anxiety’ in the past 12 months, as well as data from the same source on self-reported counselling attendance for each age group. The patterns show considerably lower utilization of counselling relative to this indicator of need amongst those aged 45 years and older, with greater disparities with increasing age group.

Figure 2.5 Mental health problems and counselling attendance – Healthy Ireland Survey (2019)

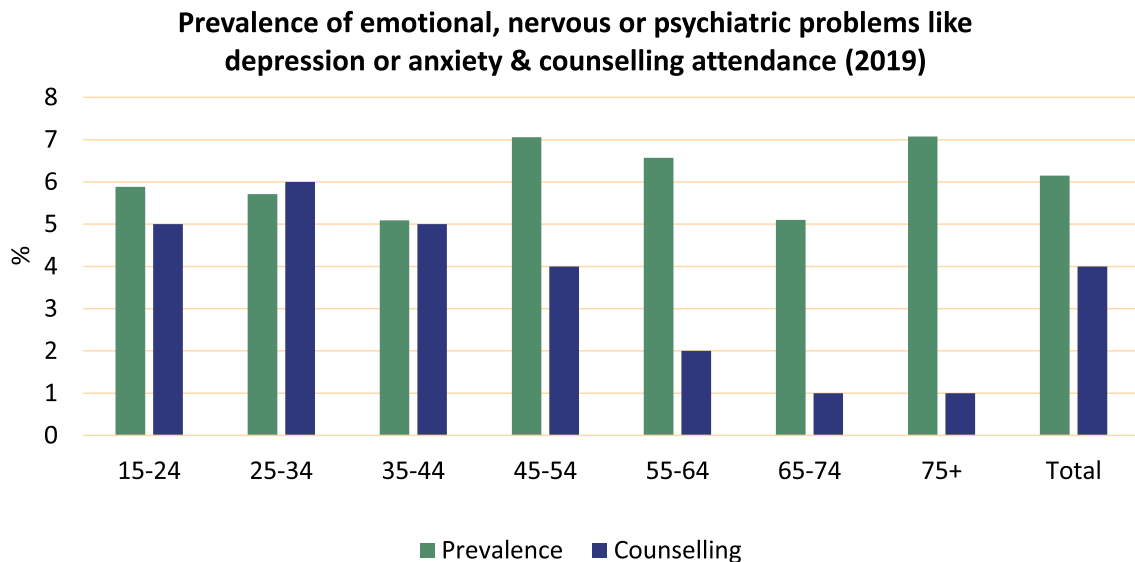
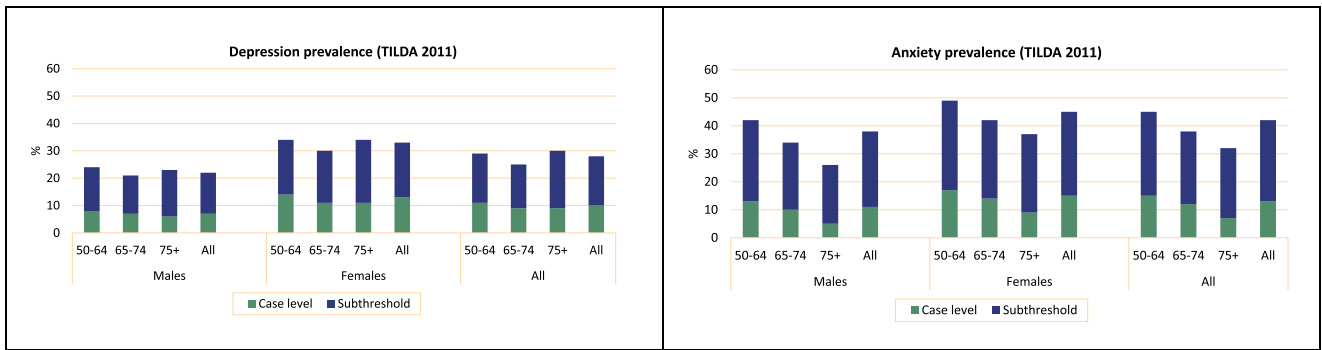


Figure 2.6 presents data from the TILDA 2011 survey of people aged 50+ in Ireland, showing relatively high prevalence of depression and even higher prevalence of anxiety (O’Regan et al, 2011). For anxiety, prevalence rates decline with increasing age group. For both conditions, females have higher prevalence than males.

Figure 2.6 Prevalence of depression and anxiety amongst 50+ age groups (TILDA 2011)



The TILDA data also shows prevalence patterns across sub-groups within the 50+ population. Figure 2.7 presents breakdowns by level of wealth. This shows strong inverse gradients by level of wealth for case level scores for both depression and anxiety.

Figure 2.7 Prevalence of case level depression symptoms by wealth amongst 50+ (TILDA 2011)

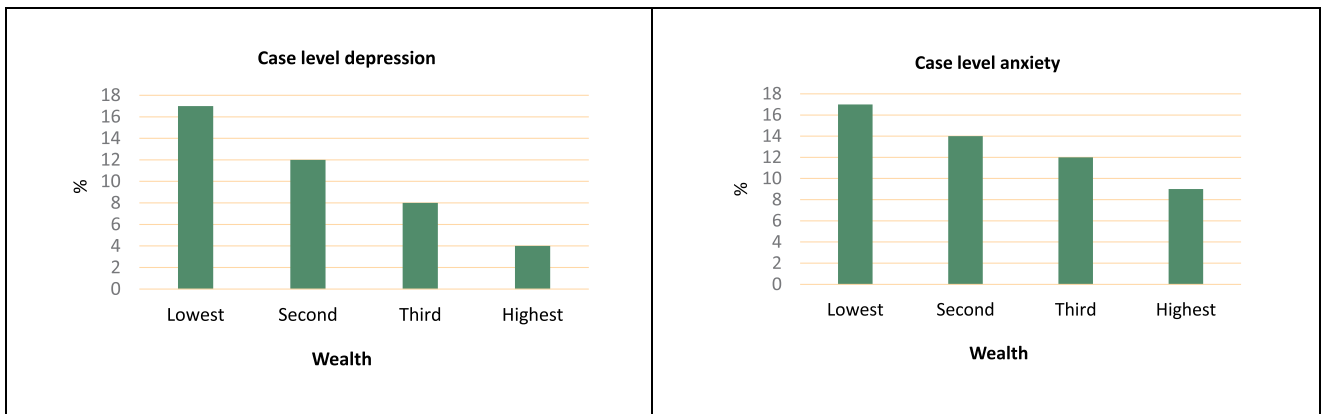
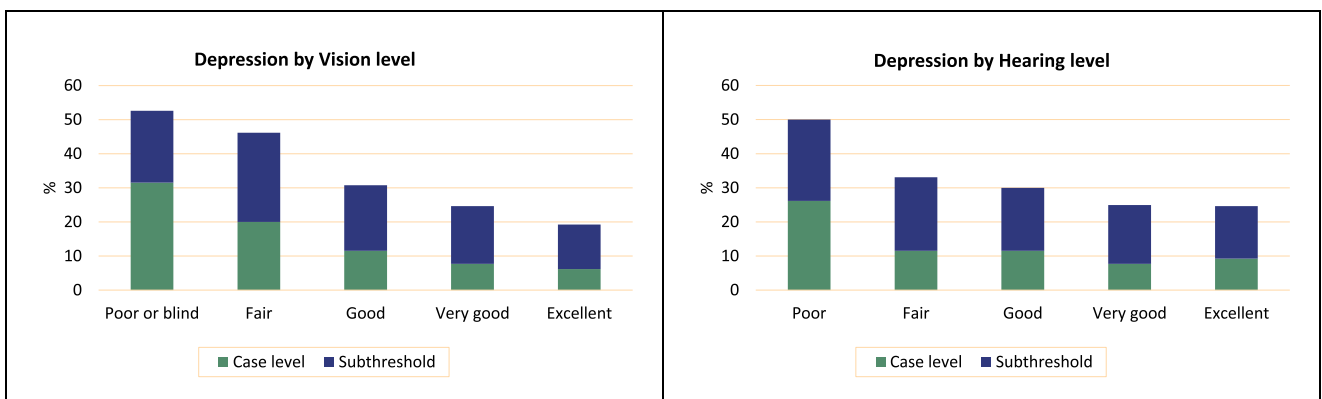


Figure 2.8 presents breakdowns of depression prevalence by degree of vision and hearing disability, showing a substantial association with increasing difficulties in these areas.

Figure 2.8 Prevalence of depression by vision/hearing disability amongst 50+ (TILDA 2011)



2.2 Digital divides

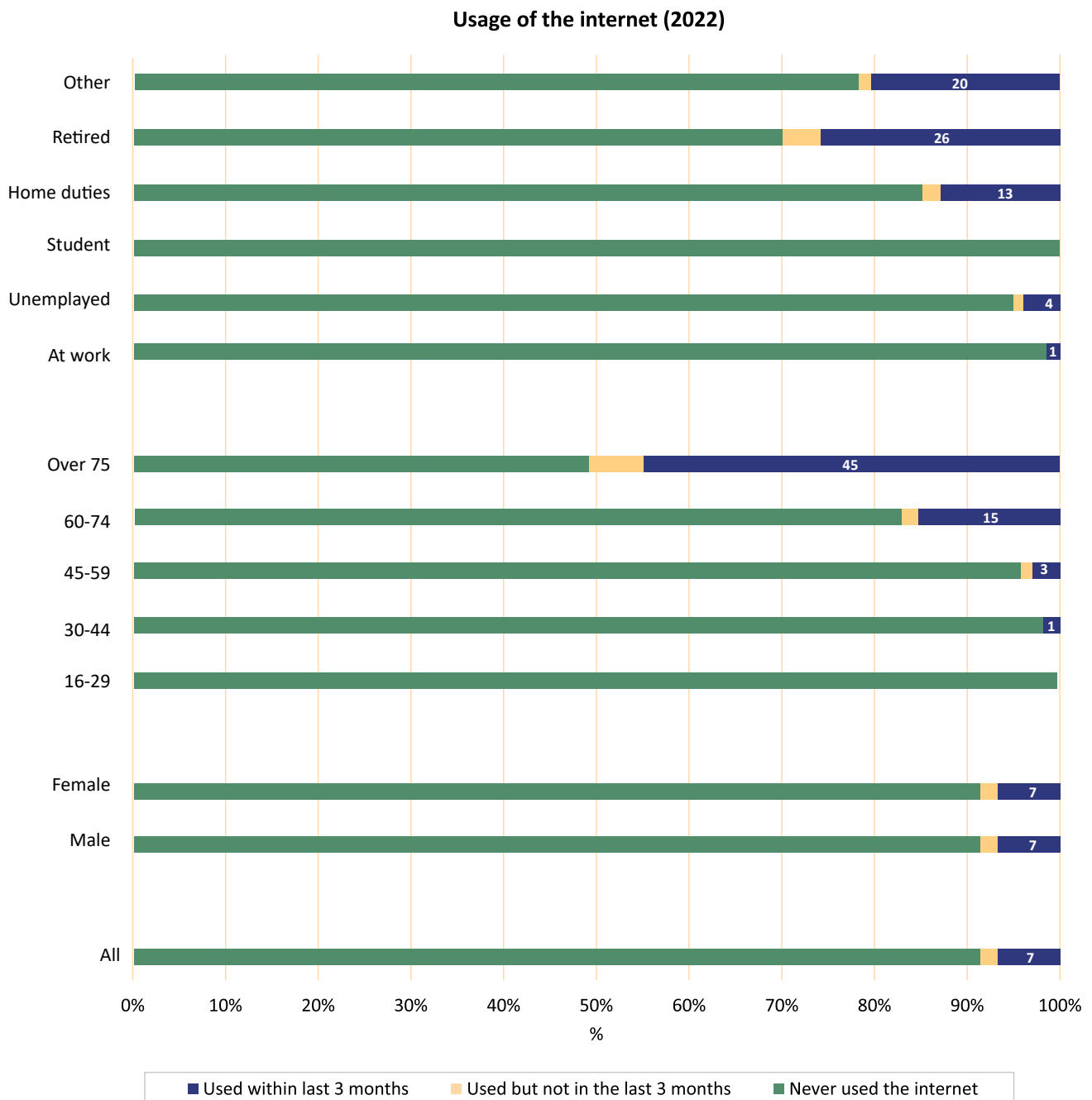
A number of recent publications have pointed to the continuing existence of population level digital divides in Ireland (NESC, 2021) and in specific contexts such as access to remote education for school-age children during the early periods of the pandemic (Mohan et al, 2020). This section presents some relevant data, focusing mainly on 'first order' divides arising from basic barriers to utilizing the internet, such as lack of suitable connectivity and/or access devices. The data comes from national statistics produced by the CSO and ComReg and shows some of the patterns across socio-economic and socio-demographic groupings in these domains.

Our analysis relies on readily available published data, which provides useful insights but is also somewhat limited. Limitations include the original survey questions not targeting issues of particular interest for current purposes as well the variation in data formats/breakdowns presented in published material. Nevertheless, the analysis possible does show a variety of manifestations of digital divides across population groups.

Internet usage

Figure 2.9 presents data on internet usage in 2022, showing just over one-in-14 (7%) in Ireland have never used the internet.

Figure 2.9 Internet usage and non-usage (Source: CSO, 2022)



The main divides at this level of granularity are age-related, with close to one-half (45%) of people aged 75+ and more than one-in-seven (15%) aged 60-74 never having used the internet but only very small numbers of other age groups. Disconnect from the workforce also appears to be a factor, for example in the somewhat lower rates of internet usage for the 'home duties' grouping.

Connectivity and access devices

Figure 2.10 shows patterns of household broadband connection across various population groups. Overall, fifteen percent of households did not have fixed home broadband connections in 2022 and the data suggests that many of these may be reliant on mobile access. Households in rural areas are less likely to have fixed broadband as are more disadvantaged households. Recent data from ComReg shows a similar picture, including higher likelihood of not having fixed broadband amongst farmers (26%), those aged 65 or older (23%), people living in rural areas (22%), and people in lower social grade occupational classifications (21%) (ComReg, 2023).

Figure 2.10 Household broadband connection (Source: CSO 2022)

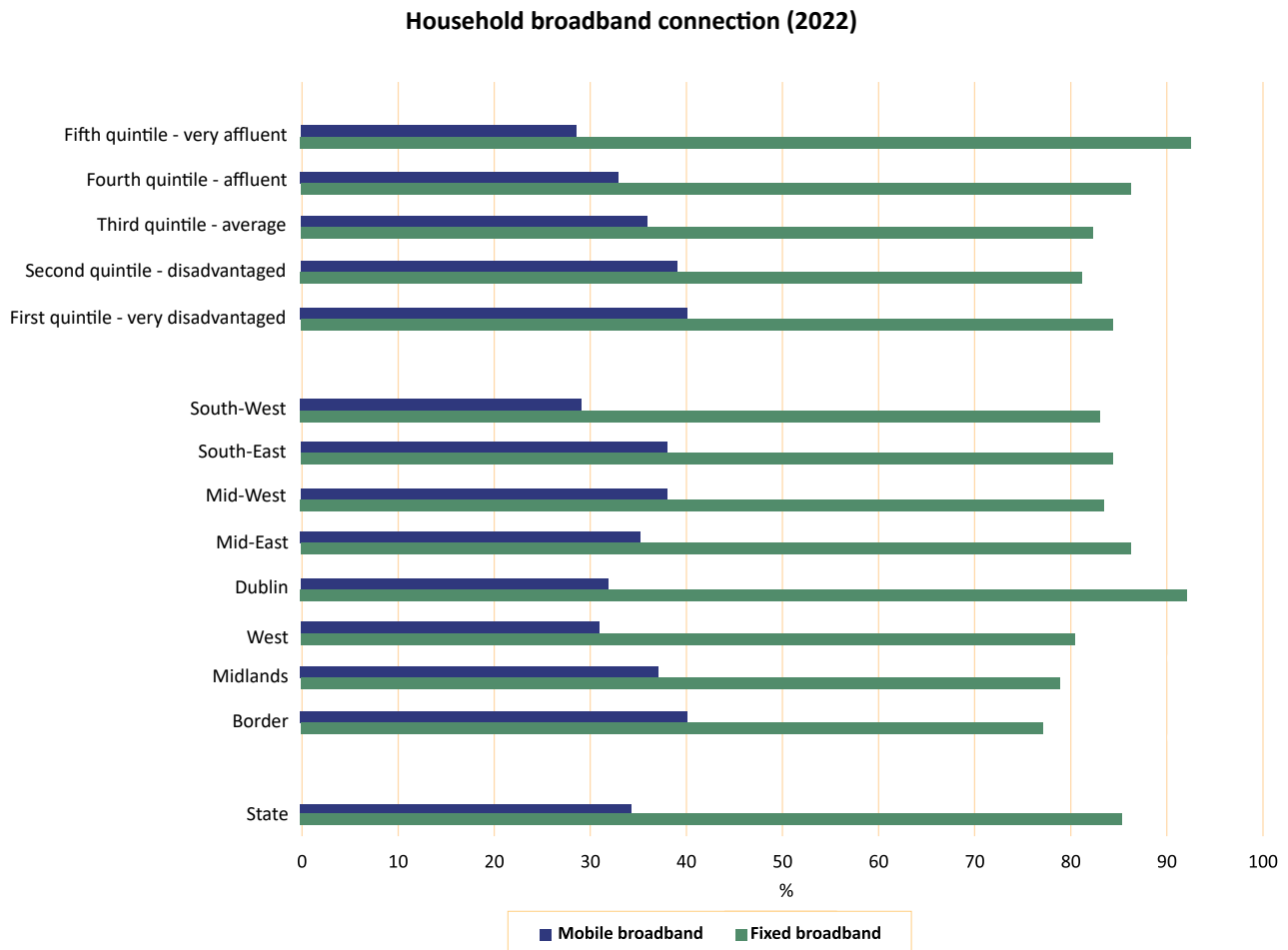
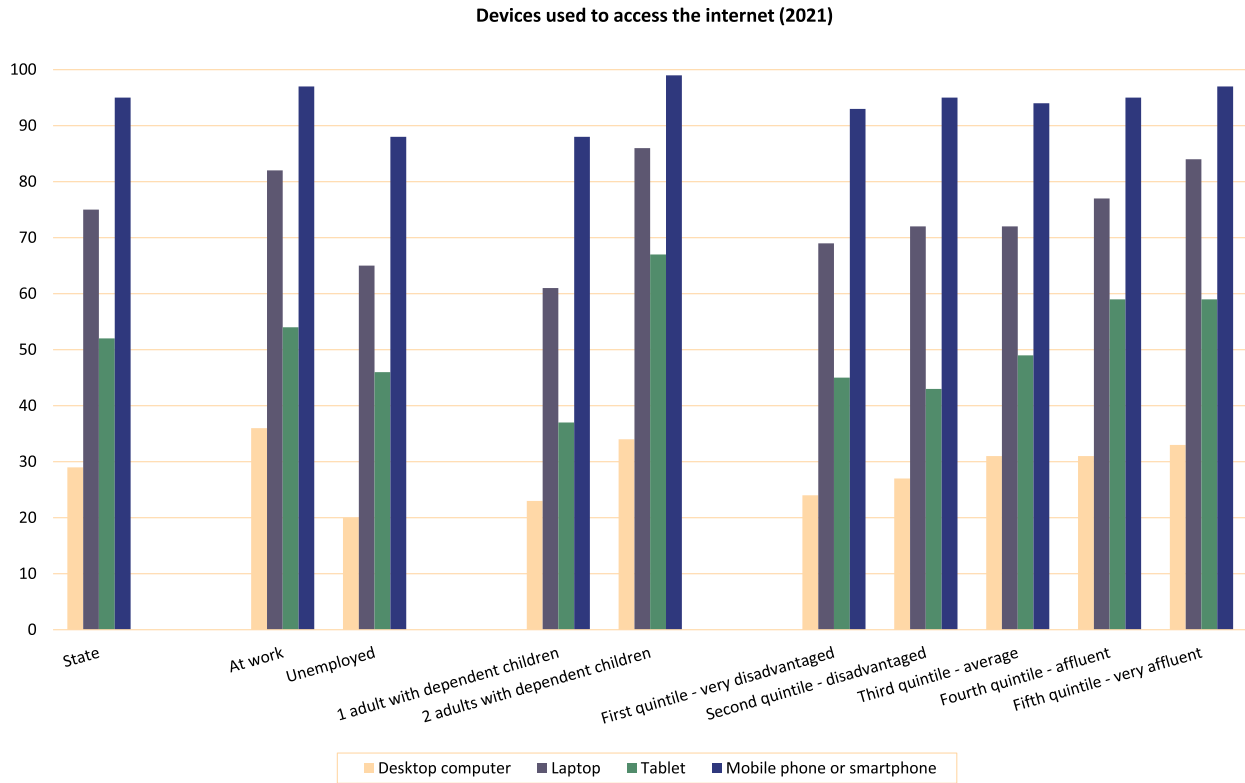


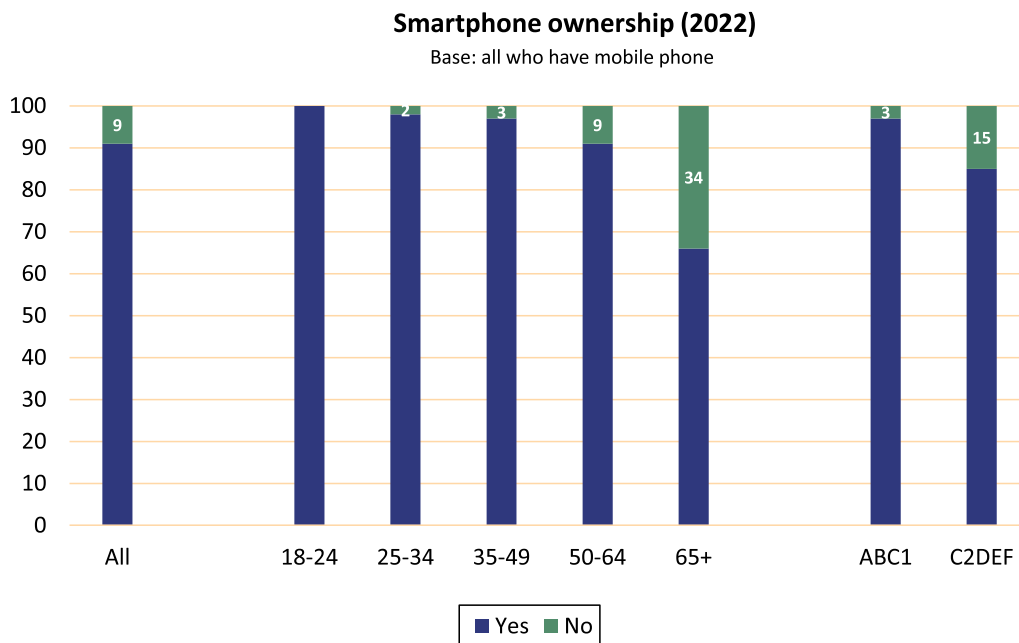
Figure 2.11 presents data showing patterns across groups in devices used to access the internet, including mobile phones as well as tablets, laptops and desktop computers. Mobile device connections may be via a mobile data network or local wifi broadband, depending on what's available to the user and what they are using it for. This can provide an alternative access route for households without fixed broadband but, depending on the mobile plan, cost disadvantages may arise if mobile data usage is extensive. The larger screens on other devices also may be more suitable for some applications and provide a better user experience. The patterns in Figure 2.11 show usage of tablets, laptops and desktops for internet access declining with increasing disadvantage. In households with dependent children, lone parent households are considerably less likely to utilize these devices. This is probably closely linked to the often much lower income levels of lone parent households.

Figure 2.11 Devices used to connect to internet (Source: CSO, 2021)



Despite the sometimes-assumed ubiquity of smartphone ownership, about one-in-eleven people in Ireland do not currently own one (Figure 2.12). Rates of ownership decline with age, and just over one-in-three (34%) people aged 65+ do not have one. Ownership rates are also lower in the C2DEF occupational grouping compared to the ABC1 grouping.

Figure 2.12 Smartphone ownership (Source: ComReg, 2022)



Amongst those who have a mobile phone, the 65+ group are considerably less likely to use mobile data and the C2DEF groups are also somewhat less likely to use this (Figure 2.13). Part of the reason may relate to affordability issues, with almost one-in-three users (31%) at least occasionally struggling with this (Figure 2.14)

Figure 2.13 Mobile service usage (Source: ComReg, 2022)

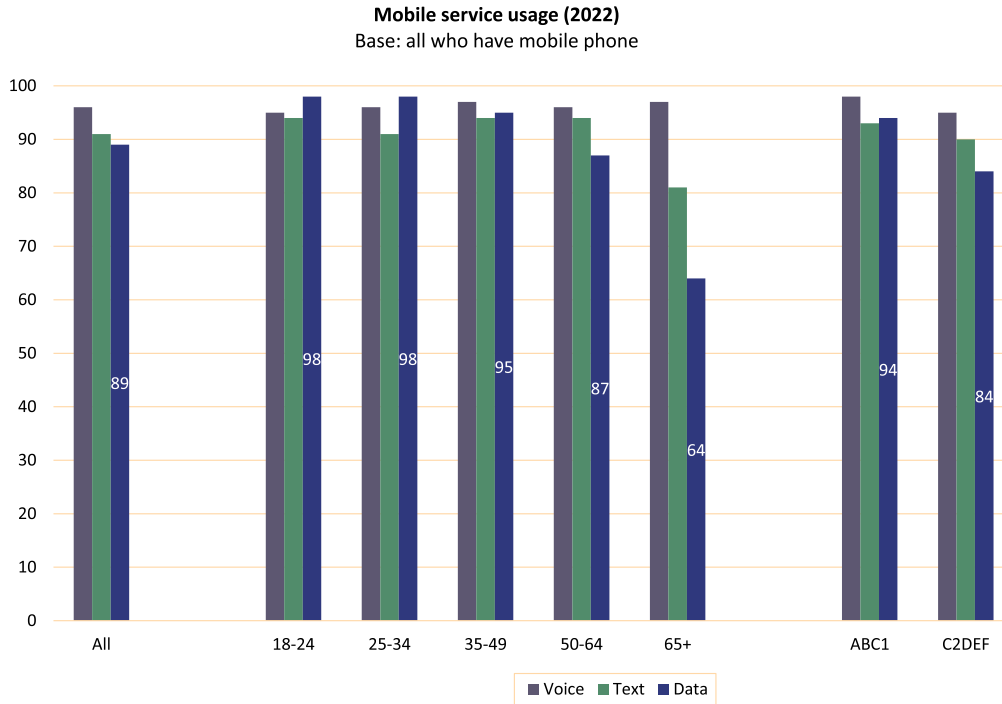
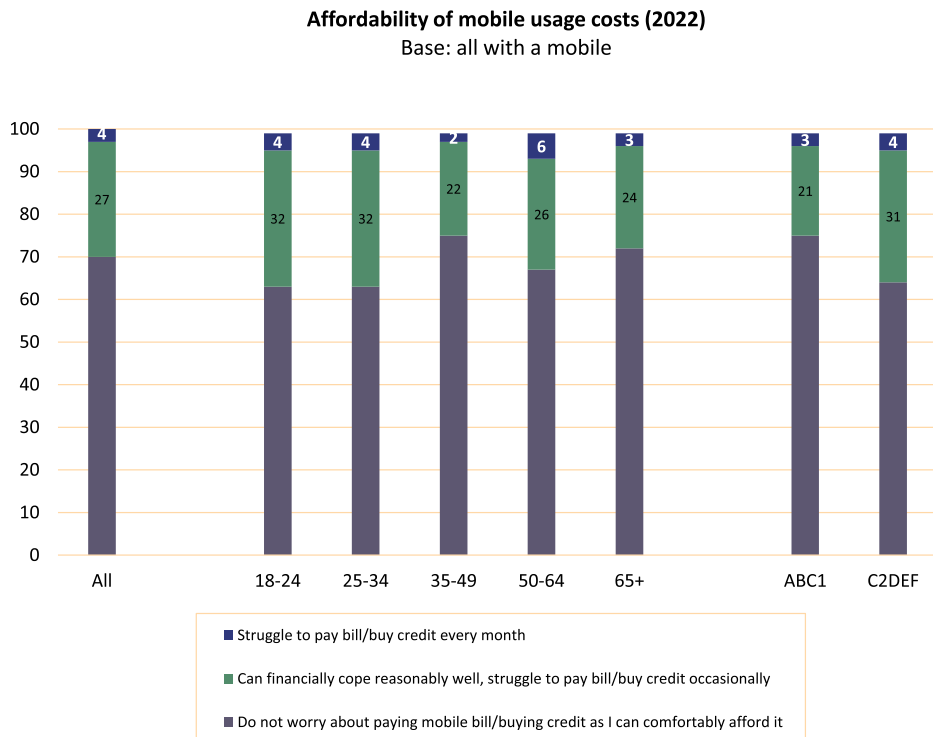


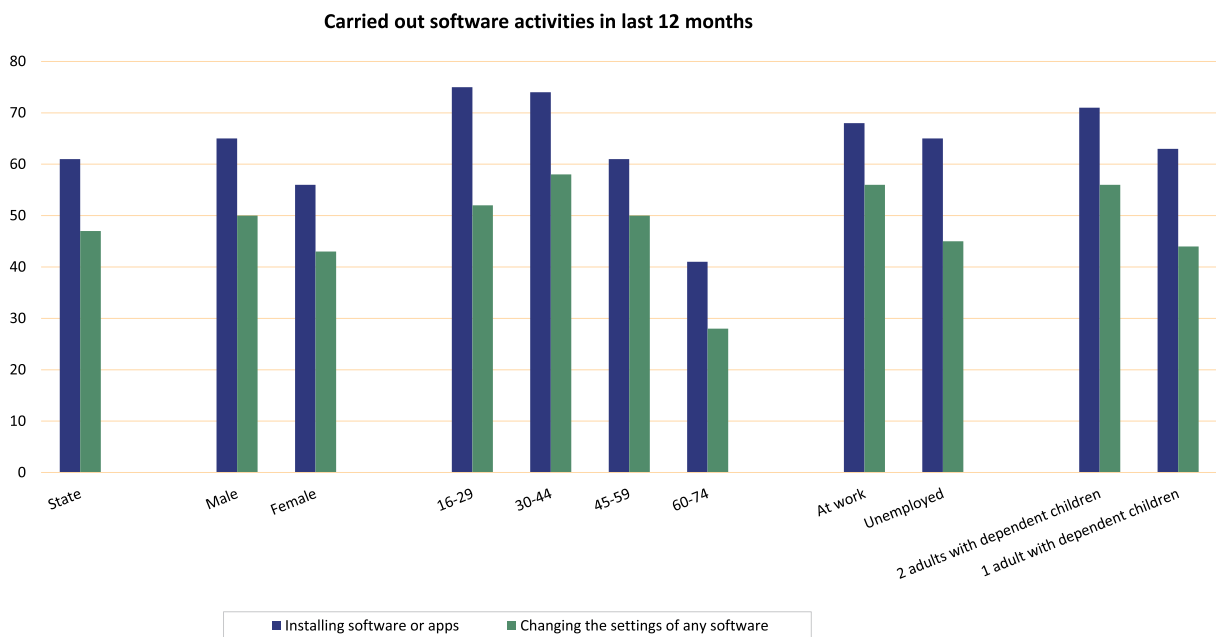
Figure 2.14 Affordability of mobile usage costs (Source: ComReg, 2022)



Digital skills

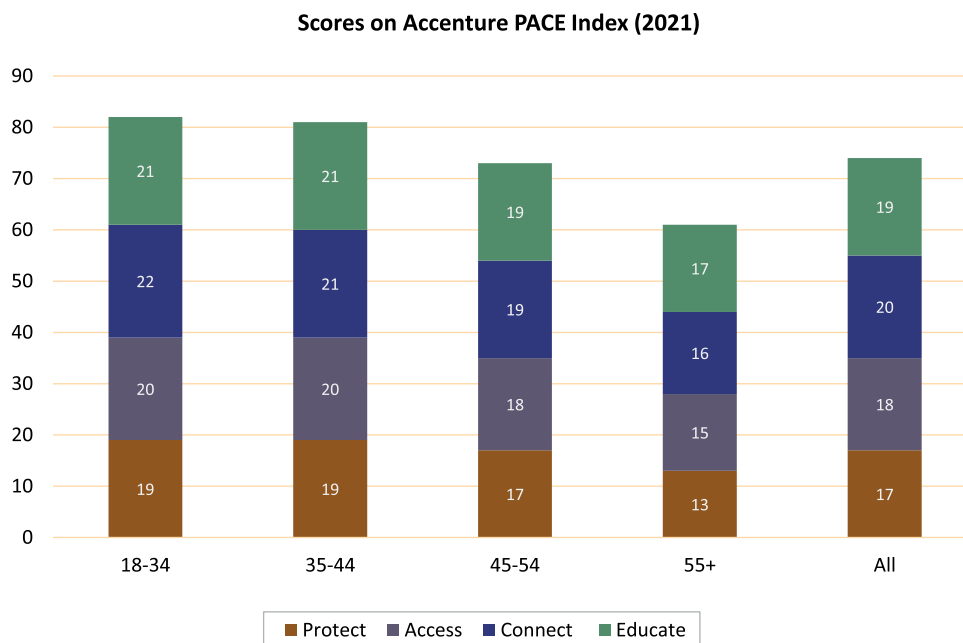
Having the required digital skills is also necessary to effectively use the internet and digital/online services and applications. Available Irish data shows digital skill divides across sub-groups in the population. For example, CSO data for 2021 indicates less likelihood of carrying out software-related activities (installing software or apps; changing the settings of any software) amongst older persons, unemployed and lone parents (Figure 2.15).

Figure 2.15 Software-related activities (Source: CSO, 2021)



Accenture’s PACE Index assesses digital skills through examination of a broader range of behaviours. Figure 2.16 shows patterns of decline in skills with increasing age group (Accenture, 2022).

Figure 2.16 PACE Digital Skills Index



Protect skills cover security-related behaviours, such as untrustworthy sources, fake news, and fraudulent emails. Access skills cover levels of comfort accessing online resources, such as online banking, job searching and engaging with government services. Connect skills cover usage of communication technologies, such as video, text, and messenger services. Educate skills cover the search for information and knowledge, and the ability to manage and collate information digitally.

2.3 Digital mental health inclusion/exclusion

Digital mental health covers a broad spectrum of online/digital applications and services (Cullen, 2018). The COVID-19 pandemic prompted rapid acceleration in the deployment of some of these, especially telemental health involving video consultations with a therapist. Currently, three forms of digital mental health are most embedded as part of the ecosystem in Ireland - online information and psycho-education, telemental health, and online CBT programmes. Mental health apps are also widely used on a self-help basis. This section looks at the extent to which digital mental health inclusion/exclusion may already be detectable in available population level data on usage of such services and applications in Ireland. As there have not yet been any dedicated surveys on this topic, the analysis relies on what can be gleaned from sources that help throw some light on the issue.

2.3.1 Online information and psychoeducation

The HSE provides an extensive range of self-help information on its 'yourmentalhealth.ie' website and has ongoing plans to further develop sign-posting and other aspects of this. During the pandemic, the HSE also prepared new online self-help and psycho-educational supports for the population as part of its psychosocial response to the pandemic (HSE, 2020), including a suite of videos. Many voluntary sector organisations in the mental health ecosystem also provide web-based information and psychoeducation on mental health issues. This sector also provides active psycho-educational programmes that reach large numbers of people every year (Mental Health Reform, 2022). Before the pandemic, delivery was mainly through more traditional face-to-face channels in group settings but the pandemic prompted many organisations to develop online versions of their programmes. Even with the resumption of physical events, online provision is likely to remain an important mode of delivery.

To avail of online mental health information via websites, users require an access device and a reasonable quality of internet connectivity. People without these basic capabilities are clearly disadvantaged in the possibility to access online mental health information. For people who have at least basic connectivity, specific end-user technical requirements (e.g., having a device with larger screen than mobile phone; having specific software) are probably less likely to be an issue than for some of the other digital mental health applications. However, people relying on access via mobile data connection may be sensitive to usage costs if their mobile package has limited data and recognition of this prompted some initiatives during the pandemic to zero-rate usage of health websites. More generally, motivation and skills to seek mental health information as well as health (and mental health) literacy levels will be important influences on usage patterns across population groups. Accessibility issues for people with disabilities are also potential barriers if online information services are not designed according to accessibility standards.

Availing of online delivery of active psychoeducation programmes (e.g., in a group setting with a tutor) has similar end-user device and connectivity requirements as online learning. This raises the access bar from both cost and skills perspectives, and increases the likelihood that first and second order digital divide factors may give rise to inequalities across population groupings.

Little direct data is currently available on patterns of usage of these forms of digital mental health across population groupings in Ireland, but the CSO information society statistics on activities people do online provide some useful insights (CSO, 2022a). Figure 2.17 shows the percentages of people who used the internet in the last three months who used it for seeking health information online. Groups less likely to have done this include those on lower incomes, older persons, and unemployed; males also show considerably less likelihood to do this than females. Differences in need for health information are unlikely to explain most of these patterns as many of the groups with lower usage would be expected to have at least as much if not more health difficulties as the comparison groups. The gender pattern may in part link to the role that mothers often play in dealing with family health matters, including seeking information about health issues arising for their children.

Figure 2.17. Second order digital divides - usage of internet to seek health information online

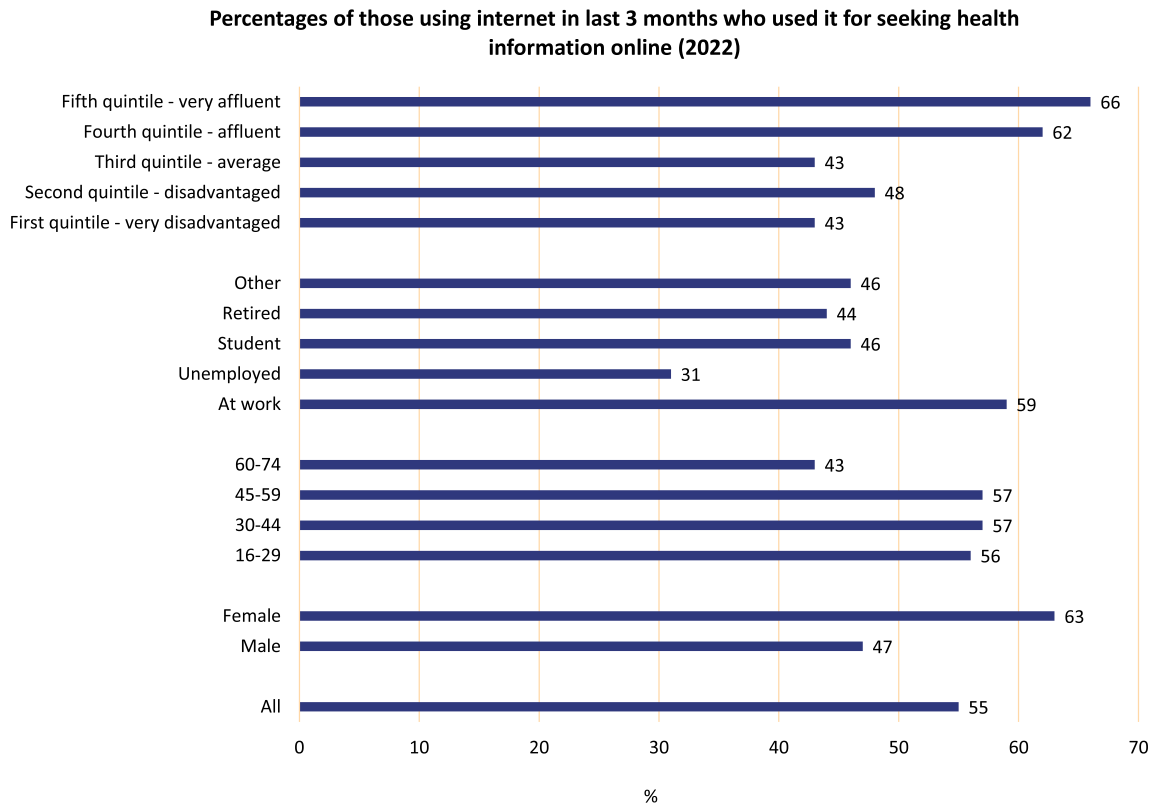
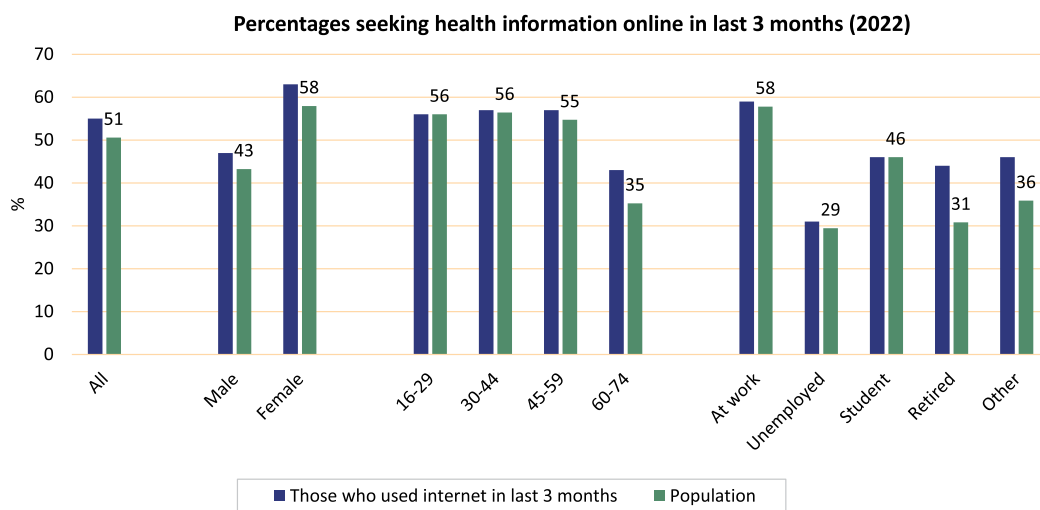


Figure 2.18 shows the combined effects of first order digital divides (reflected in non-usage of the internet in the last three months or ever) and the second order divides amongst those who did use the internet in the last three months. This shows the absolute percentages of the entire population in each group who sought health information online. Overall, just over one-half of the population (51%) did this in the last three months, falling to less than one-third for the unemployed and retired.

Figure 2.18 Seeking health information online – impacts of first and second order digital divides



2.3.2 Telemental health

Telemental health refers to provision of remote therapy sessions through voice, video or text channels. Before the pandemic, a relatively small number of established mental health services were offering such services and telemental health sessions were still a very small fraction of the total volume of low intensity, sessional-based therapy for mild to moderate common mental health difficulties.

The pandemic prompted widespread deployment of telemental health during the lockdowns and social distancing regimes. This included the HSE's video enabled care programmes (HSE, 2021) and utilization of phone and video consultation within the Counselling in Primary Care programme (CIPC, 2022), as well as extensive utilization by voluntary sector organisations providing mental health counselling/ psychotherapy services (Mental Health Reform, 2022). Both the CIPC programme and many of the voluntary sector services plan to continue offering remote/online as an option alongside the return to face-to-face services.

The Department of Health also funded some targeted online counselling programmes for population groups affected by the pandemic, such as people out-of-work and receiving pandemic-related welfare payments. These programmes have since expanded to address other target groups including people impacted by the ongoing crisis in Ukraine, those registered to the Defective Concrete Blocks Grant Scheme and those living with chronic illness. This shows the positive potential to utilize telemental health for reaching groups that might otherwise face disadvantages in accessing mental health services.

However, if not addressed, wider digital divide factors may affect the opportunities for particular population groupings to avail of telemental health services. In comparison to seeking health information online, effective usage of video consultations generally imposes somewhat heavier requirements regarding suitable access devices and connectivity, and this can have implications for ease of access and costs. For example, for people relying on mobile data for internet connection, quality video calls require considerable bandwidth and may not be feasible/affordable for those on low-cost and limited data plans. Anyway, mobile handsets may not always provide an acceptable user experience for video consultation in comparison to other devices with larger screens such as tablets. In this study, consultation with some extensive users of videocalls for ongoing engagement with mental health services indicated a preference for larger screen devices.

Software requirements/skills may also be an issue, depending on the video platform the mental health provider utilizes. Some video platforms are more likely to be GDPR compliant than others, whereas more ubiquitous offerings such as WhatsApp offer easy and potentially low-cost options but raise privacy considerations. Accessibility issues also arise for people with sensory and other disabilities, with some platforms offering more features than others in this regard.

Although little direct data is available on the impact of such factors on equality of access to telemental health in Ireland, the CSO information society statistics on activities people do online again offer some useful insights. For example, general patterns of utilization of the internet for video calls provide an indication of the likely readiness across population groupings for applications such as telemental health. Figure 2.19 presents data on usage of the internet for phone/video calls (for any purpose) amongst those who used the internet in the past 3 months. Overall, reflecting impacts of the pandemic, levels of usage were quite high amongst all groups using the internet. Levels of usage were lower amongst more disadvantaged groupings, unemployed, and older persons although still quite substantial at two-thirds or more of internet users in each grouping.

Figure 2.19 Second order digital divides - usage of internet for phone/video calls

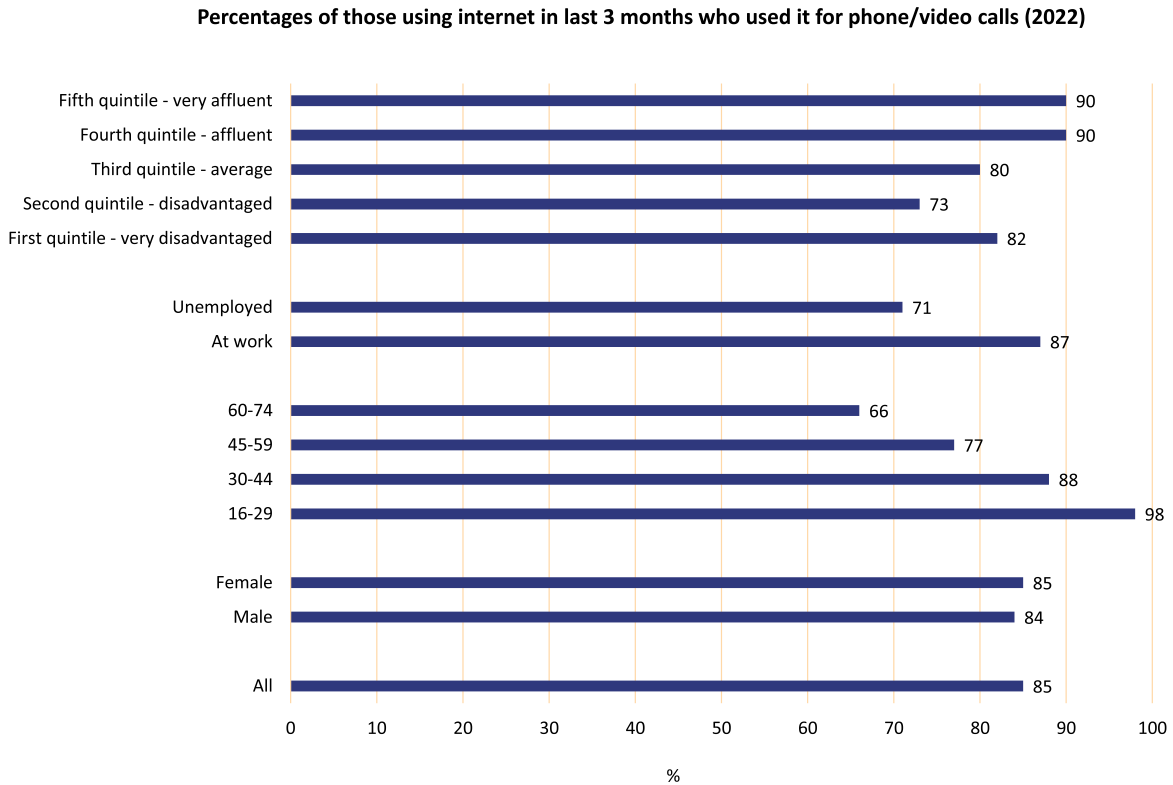
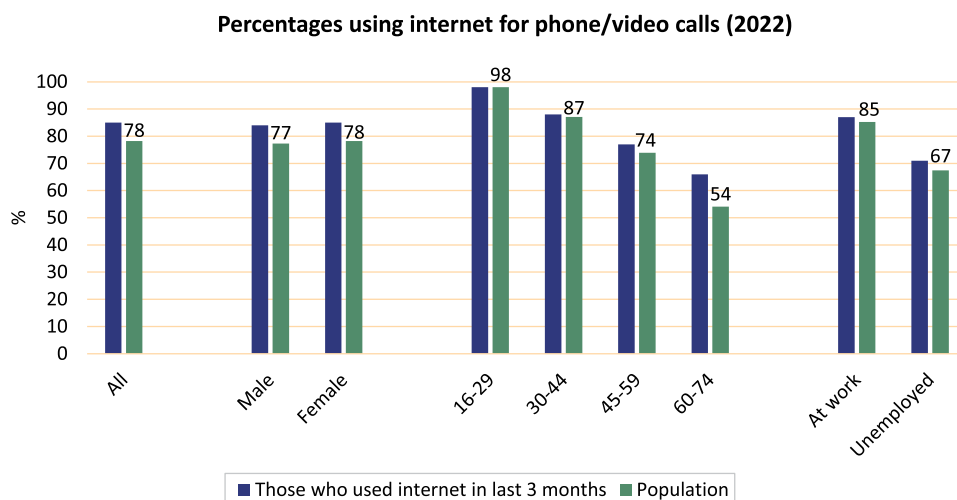


Figure 2.20 shows the combined effects of first order and second order digital divides on the absolute percentages of the entire population in each group who used the internet for this. Overall, more than three-quarters of the population (78%) did this in the last three months, falling to just a little over one-half for the 60-74 years age group.

Figure 2.20 Usage of internet for phone/video calls – impacts of first and second order digital divides



2.3.3 Online CBT programmes

Cognitive Behavioural Therapy (CBT) is a commonly utilized approach to support people with mild to moderate mental health conditions such as anxiety and depression. CBT is a structured approach that includes psychoeducation and cognitive-behavioural exercises for users to practice between sessions. The structured and protocolized approach lends itself well to computer-based and online delivery of these components, and online programmes are offered with varying degrees of support from a therapist or other supporter. In the last couple of years HSE has begun to provide access to online CBT through commissioning of a service provided by Silvercloud. GPs and other practitioners can refer people for free online CBT programmes, and more than 6,000 people have used the service in the past two years. Published data on users of this service show that the majority are in the younger age groups, with much lower numbers in the 55-64 and 65+ age groups.

Figure 2.21 Age composition of people attending counselling and those using online CBT

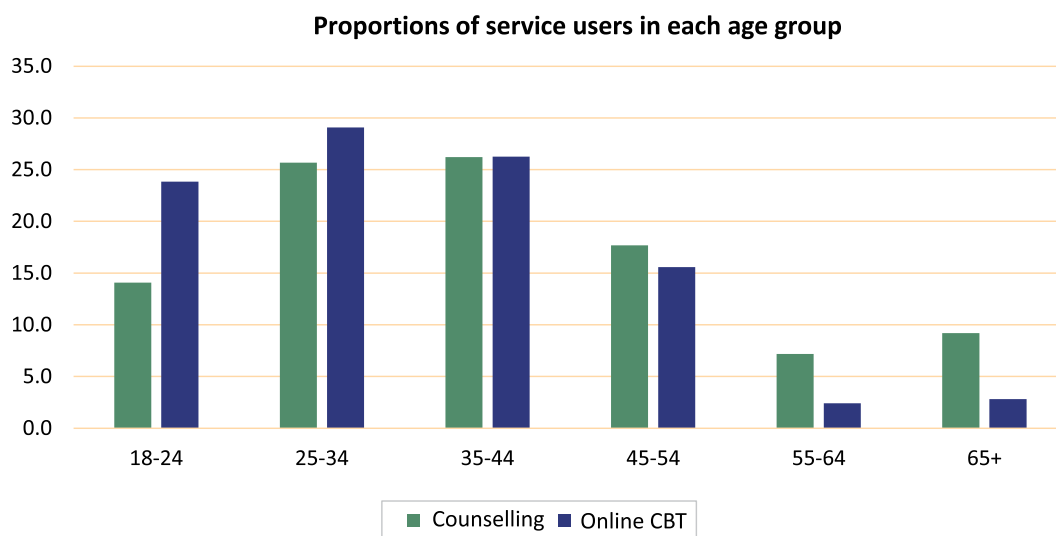


Figure 2.21 compares the age breakdown for online CBT with that for self-reported usage of counselling from the Healthy Ireland survey of 2019, and shows the relatively greater under-representation of the older age groups amongst those using online CBT. The estimated age composition of general counselling service users derives from an application of rates of reported counselling attendance by age group (Healthy Ireland, 2019) to the proportion of the population in each age group; online CBT data comes from a recent report on over 6,000 users of the HSE-funded service (Silvercloud, 2022).

Without direct investigation, it is not possible to know what factors underlie the observed patterns. Influences might include GPs more likely to refer younger people to online CBT and/or lack of interest amongst older people to pursue a referral if offered. The latter might be influenced by digital divide factors and/or older persons preferring general counselling rather than CBT, irrespective of whether the CBT is through traditional approaches or online. Whatever the mix of factors involved, the upshot is older age groups appear less likely to avail of and benefit from opportunities presented by online CBT.

2.3.4 Mental health apps

There appears to be little Irish data available on patterns of usage of mental health apps across different population groupings. Evidence from other countries suggest that the various divides discussed above are also likely to apply. For example, a recent national survey in Wales found disparities across population groups in usage of digital technologies to monitor aspects of health (Davies et al, 2019). Levels of usage for any of a range of purposes (fitness, food intake, sleep, stress/anxiety, mental wellbeing, and other areas) tended to decrease with increasing age and with increasing deprivation level.

2.4 Summary

Available data shows the existence of both mental health inequalities and digital divides, with strong overlap between the groups affected by each. This means that these groups are likely to be at risk of experiencing digital mental health divides as well.

Nationally representative surveys such as the Irish Health Survey show substantially greater prevalence of mental health difficulties amongst more disadvantaged socio-economic groups as well as significant under-utilisation of mental health services relative to prevalence of need. This survey and Healthy Ireland surveys also show substantial under-utilisation of mental health services relative to need amongst older age groups, and data from the TILDA study for the 50+ age groups show much higher prevalence of mental health difficulties amongst less advantaged older people and those with vision or hearing impairment.

Data from CSO and ComReg surveys provide a range of evidence on digital divides in Ireland today. The most obvious is that many older people do not use the internet, with this the case for almost one-half of those aged 75 or older. Available data also shows lower digital literacy/skills amongst older people and disadvantaged groups. Access to fixed home broadband is still an issue for substantial numbers of households, with more than one-in-seven not having this connectivity. Apart from those affected because of rurality, groups less likely to be connected include older persons and more disadvantaged socio-economic groupings. Mobile access can provide an alternative for some people, although affordability of mobile data charges may be a barrier for more disadvantaged groups to use services that consume a lot of data. Additionally, quite substantial numbers of people do not have a smartphone, including just over one-in-three of those aged 65 or over. Reliance on a smartphone may also be a disadvantage for using applications where a larger screen device would be preferable, and likelihood of having such a device decreases amongst more disadvantaged socio-economic groups.

Groups experiencing both mental health inequalities and digital divide barriers are at a particular disadvantage regarding access to digital mental health and to the benefits this can offer. The evidence summarized above suggests that substantial numbers of people are now at risk of this 'double jeopardy'. Despite the absence of dedicated surveys of digital mental health usage patterns in Ireland, evidence of digital mental health divides is already becoming apparent in various ways. For example, older people and more disadvantaged socio-economic groups are less likely than other groups to search online to seek health information. Data on utilization of publicly-funded online CBT programmes in Ireland also show substantial under-representation of older age groups.

Practitioner Survey



3 Practitioner survey

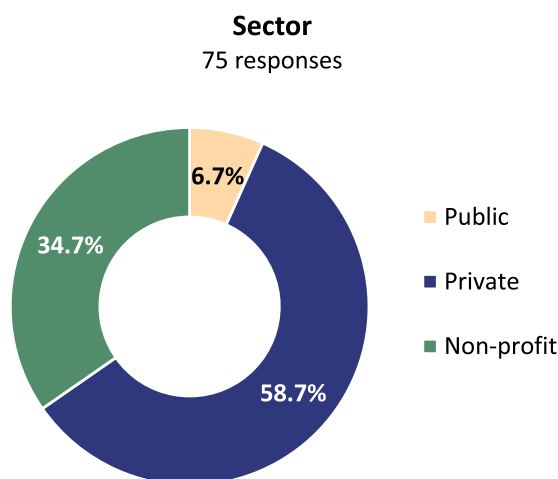
This chapter presents results of primary research conducted as part of the current study. Mental health practitioners were surveyed about their experiences regarding digital divide factors affecting access to remote consultations and other forms of digital mental health for the client groups they work with. The online survey mainly targeted counsellors/psychotherapists and was advertised to the membership of the Irish Association for Counselling and Psychotherapy (IACP), a large representative body of practitioners in this field.

3.1 Sample profile

Seventy-six practitioners completed the survey, representing about 1.5% of the IACP membership. Although too small a sample to claim full representativeness, the mix of working in private practice or in the non-profit sector aligns well with the profile from much larger surveys by IACP (IACP, 2022).

Most of the 76 respondents were counsellors/psychotherapists (94.7%), with just a few other practitioners (psychologists, peer support worker). Figure 3.1 shows the sectoral profile of where respondents worked. Almost three-in-five (58.7%) worked in the private sector and just over one-third worked in the non-profit sector, with a small number working in the public sector.

Figure 3.1 Sectoral profile of where respondents worked

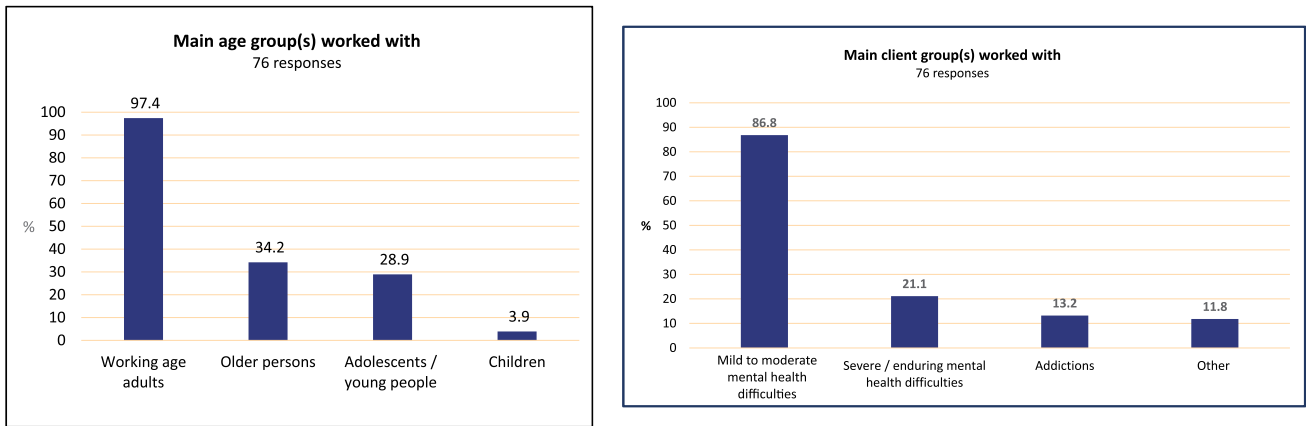


The majority (88.2%) worked on a paid basis, with some (17%) doing both paid and voluntary/unpaid work, and a minority (11.8%) reported only working on a voluntary/unpaid basis. Just over three-quarters (76.0%) worked in individual or group practices, just under one-in-ten (9.3%) worked in a larger mental health organization, and one-in-seven (14.7%) worked in mental health services within an organization with a wider remit. The vast majority of practitioners working in the latter two settings were operating in the non-profit sector.

3.2 Client groups worked with

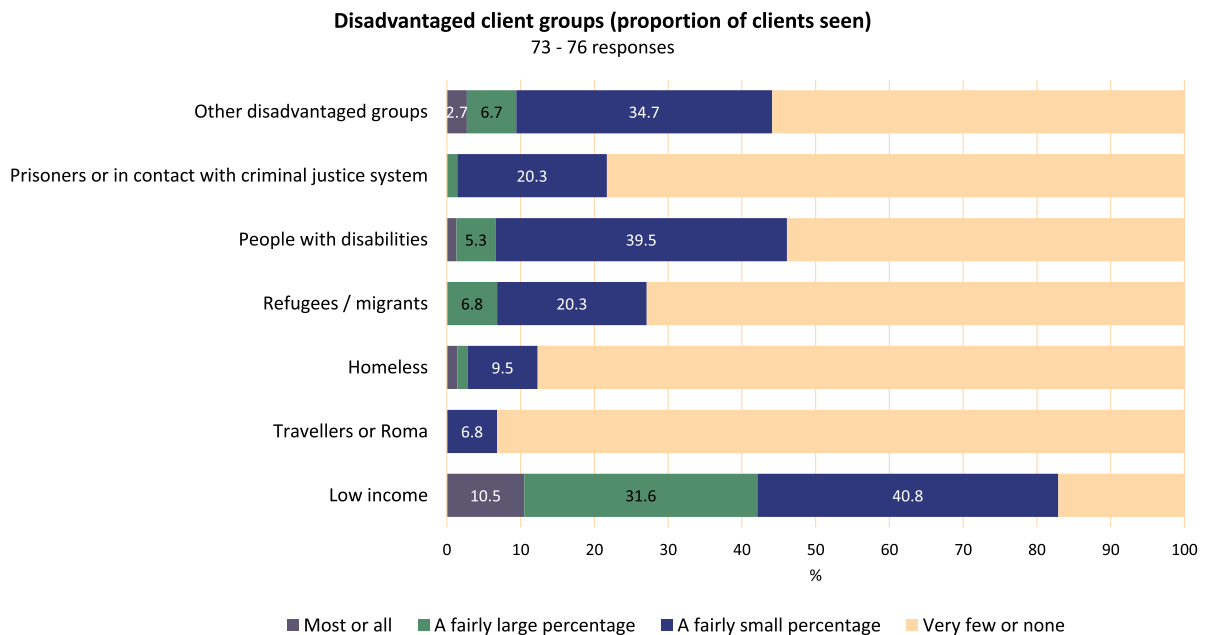
This section presents a general profile of the client groups the respondents worked with and then looks at the extent they work with disadvantaged groups. Practitioners most commonly worked with adults of working age and clients with mild to moderate mental health difficulties, although substantial minorities also worked with older persons and or adolescents/young adults and with clients with severe/enduring mental health difficulties or addictions (Figure 3.2).

Figure 3.2 Age groups and client groups worked with



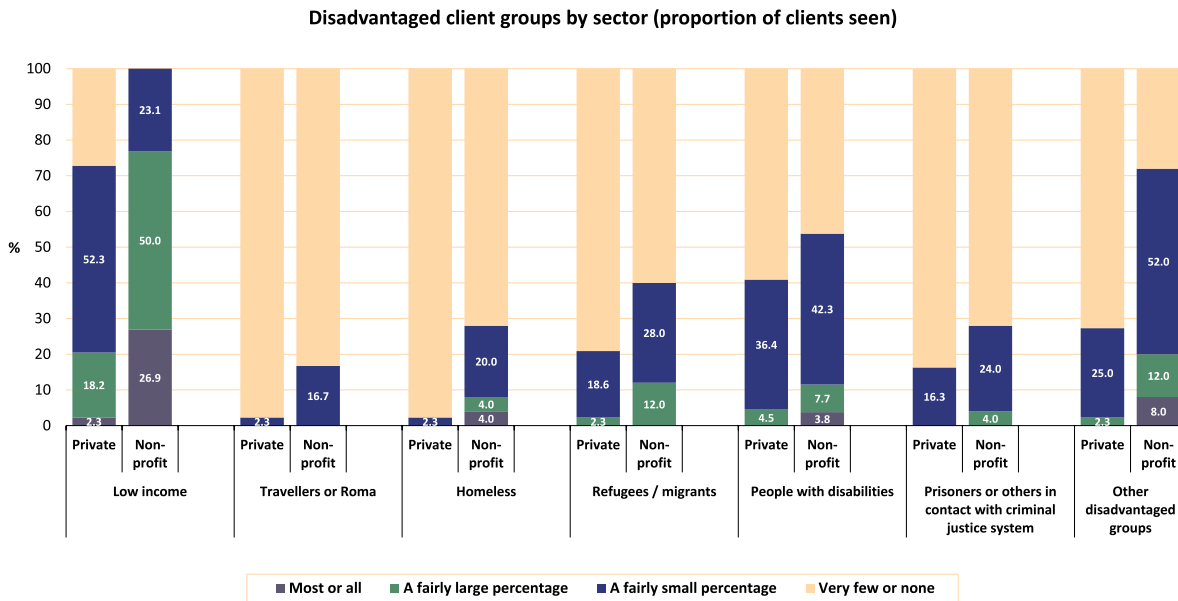
The survey asked about the proportions of clients seen that fall within various categories of disadvantage. Figure 3.3 presents the overall profile across the sample of practitioners and Figure 3.4 compares the patterns for practitioners working in the private and non-profit sectors.

Figure 3.3 Disadvantaged client groups as a proportion of clients seen



Across the entire sample, low income is the most common form of disadvantage, with 42.1% reporting this group making up a fairly large percentage or more of all the clients they see. Practitioners working in the non-profit sector were much more likely (76.9%) to have large percentages of low-income clients compared to those working in the private sector (20.5%), as well as generally tending to have larger percentages of the various other disadvantaged groupings.

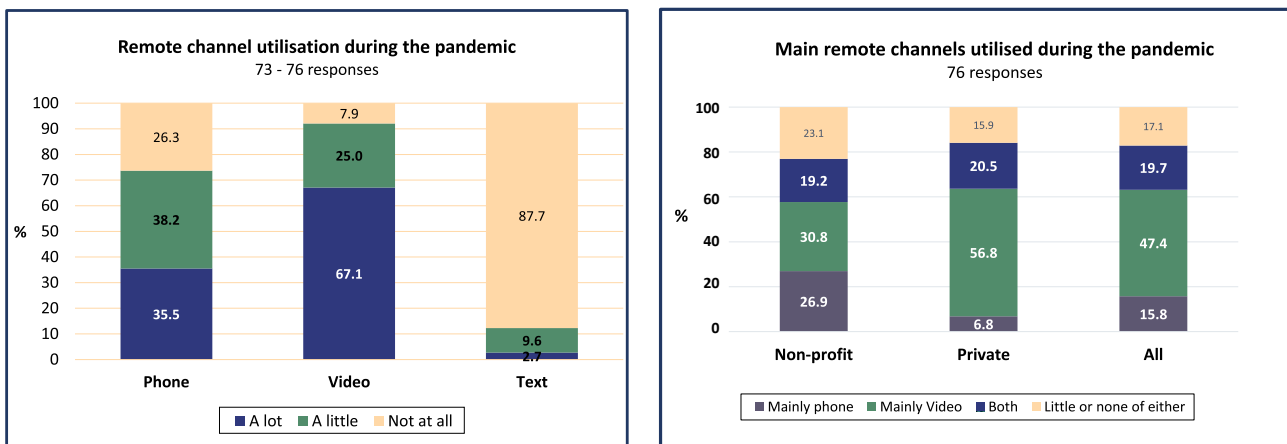
Figure 3.4 Disadvantaged client groups as a proportion of clients – private and non-profit practitioners



3.3 Remote consultations

Almost all respondents (97.4%) reported having at least some remote consultations with clients during the pandemic. Figure 3.5 shows the channels utilized for remote consultation.

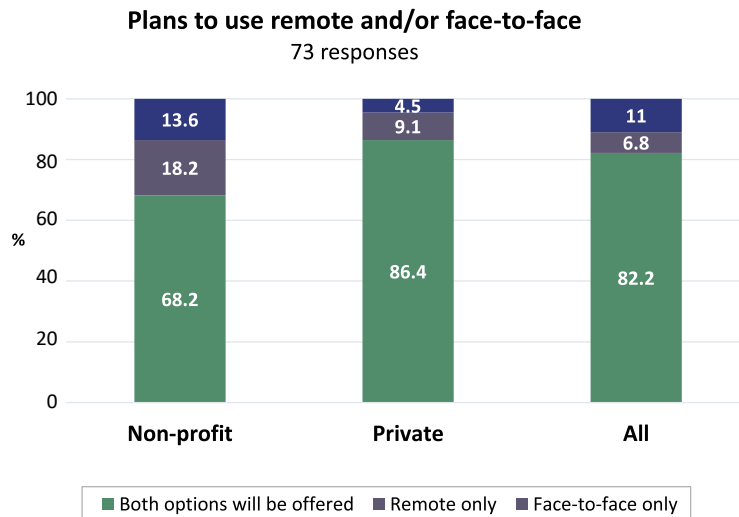
Figure 3.5 Channels used for remote consultation during the pandemic



Across all respondents, video consultations were most likely to be used a lot, with more than two-thirds reporting this (67.1%). Just over one-third (35.5%) reported using phone consultations a lot, with very little reported usage of text consultation. Private practitioners were considerably more likely than non-profit practitioners to mainly utilize video consultations, with the latter reporting relatively more utilization of phone consultation. This may be an indication of cost sensitivities or other barriers to utilizing the more technologically-demanding video consultation option for non-profit sector services and their users.

Figure 3.6 shows the practitioners' plans regarding using remote and/or face-to-face consultations after the pandemic. A large majority (82.2%) plan to offer both options, just over one-in-ten (11.0%) plan to offer remote only, and a small number (6.8%) plan to only offer face-to-face consultations.

Figure 3.6 Plans to use remote and/or face-to-face consultations



Comparing non-profit and private practitioners, a majority in each group plan to offer both options (hybrid approach), although this is somewhat more likely amongst the private practitioners. The patterns suggest there may be some tendency for non-profit providers to opt for a single-channel approach, possibly reflecting varying combinations of resource issues at the provider end and digital divide issues at the user end.

3.4 Digital divides

The survey asked practitioners about the nature and extent of any digital divide factors that might arise for the client groups they work with, which client groups are most likely to be affected, and whether they or their organisation/service have taken any actions to address these issues. The extent digital divides issues will be visible to practitioners may be limited to what they know about those clients they have actually had contact with unless they work in a context where the needs and circumstances of the wider target group they serve are known. This might be more likely for practitioners working in non-profit organisations, especially those working in organisations with a wider remit beyond mental health.

3.4.1 Extent of the issue

Figure 3.7 presents the patterns for the entire sample, and shows the most commonly-identified area of difficulty was not having access to a suitable private space for a remote consultation. Almost one-third (31.5%) of practitioners identified this as likely to be an issue for a fairly large percentage or more of the client groups they work with. Although other areas of difficulty were less visible to practitioners, in part this might be because such difficulties have already prevented people becoming known to them as potential clients in the first place.

Figure 3.8 compares responses of non-profit and private practitioners on this survey item, showing non-profit practitioners reporting considerably higher likelihood difficulties amongst client groups they work with. This is apparent not just for lacking access to a suitable private place but also for the other areas of difficulty – lack of equipment, not having confidence/skills, connectivity, and costs of connecting via mobile plan.

Figure 3.7 Proportion of client group that might have difficulties to use your service via remote or online channels for specific reasons

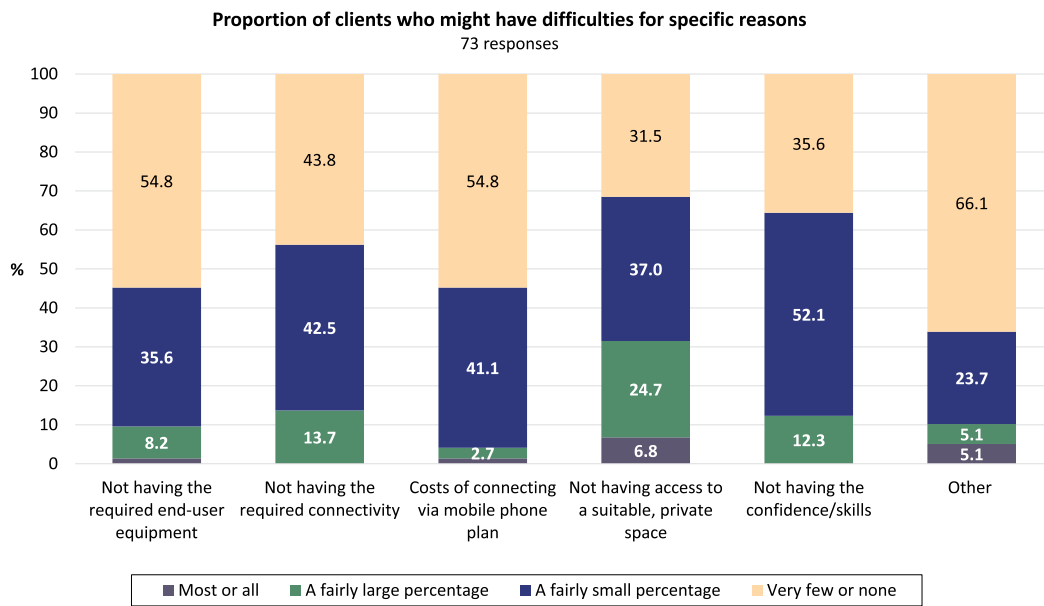
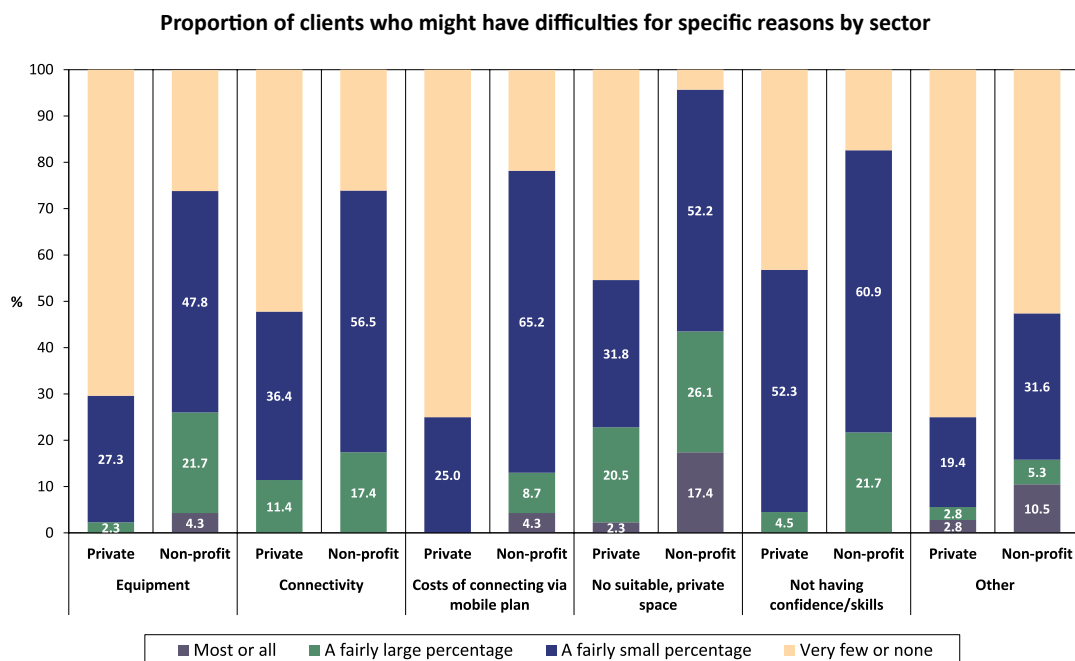


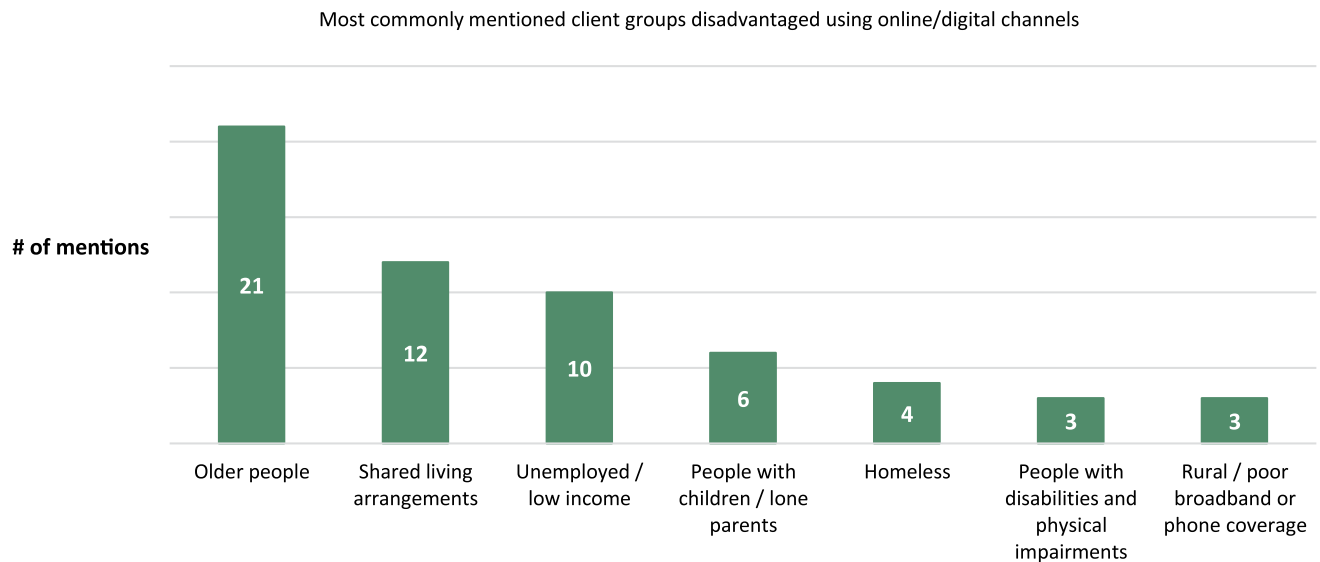
Figure 3.8 Proportion of client group that might have difficulties to use your service via remote or online channels for specific reasons – comparison of non-profit and private practitioners



3.4.2 Client groups most likely to be disadvantaged

The survey also asked an open-ended question on which client groups, if any, are most likely to be disadvantaged in these ways. Figure 3.9 presents the most frequently mentioned groups/situations.

Figure 3.9 Client groups disadvantaged using online/digital channels



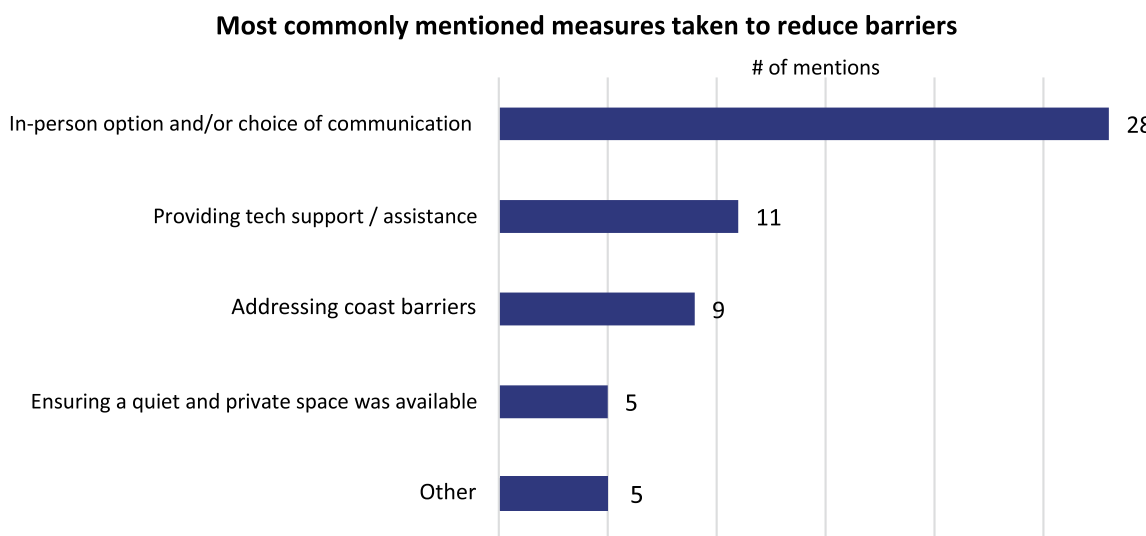
Across the entire sample, **older persons** were most commonly mentioned as disadvantaged, especially due to their lower digital confidence and skills. **Shared living arrangements** were also quite frequently mentioned, including crowded households, young adults living at home with parents, people working from home, and congregated settings like direct provision with limited availability of quiet or private space. Parents with young families and lone parents were also specifically mentioned in this context. Lack of safety was another aspect, including situations with domestic violence, coercive relationships or other family difficulties. Challenges may also arise for people experiencing homelessness, in active addiction or living in other chaotic situations. Financial constraints arising from **low income**, including unemployed and people dependent on social welfare payments, were also quite commonly mentioned. Other sources of disadvantage included disability (dexterity, vision, hearing), language barriers, particular presentations or mental health difficulties, experience with particular platforms (e.g., Zoom), and unfamiliarity or bad previous experience with therapy.

3.4.3 Actions to address digital divides

Overall, fifty percent of respondents said they or their service/organization had taken some action to reduce digital divide barriers, with non-profit practitioners (56%) a little more likely to report this than private practitioners (46.3%). Figure 3.10 presents the most commonly mentioned measures.

Measures such as maintaining an **in-person option and/or choice of in-person or remote options** were most frequently mentioned. Flexible approaches were commonly mentioned for this, including: having a telephone option available (as an alternative to video); switching platforms if needed or using a commonly available platform (e.g. WhatsApp); offering flexibility around session days/times for remote consultations; and commencing with a face-to-face session where the online option can be discussed for those who might benefit from it (e.g. having travel difficulties or cost), clarifying potential options and obstacles from the outset and deciding on what works best.

Figure 3.10 Most commonly mentioned measures to reduce barriers



Providing tech support or assistance was also a frequent form of help, covering a range of informal and more structured approaches. Activities mentioned included: basic tech support, talking a client through getting connected or using different platforms; sending clients a written information pack including a technical troubleshooting guide; initial detailed explanation by receptionist on how phone and Zoom calls work; running classes aiming to make people more comfortable with using their smartphone or tablet; other services available within centres to support people using phones and tablets.

Addressing cost barriers was also mentioned quite commonly. Some examples specifically relevant for digital divide issues included the practitioner covering the session connection costs and service providers lobbying for funding to provide equipment and mobile data packages for clients. Practitioners more frequently mentioned efforts to avoid affordability barriers relating to session costs for disadvantaged groups, including negotiable fees, a 'pay-it-forward' ethos, and free services for some disadvantaged groups (e.g., homeless).

Ensuring a quiet and private space was available for people accessing services was another measure taken to reduce barriers. During the pandemic, some services made rooms available that clients could book to access online sessions in private. Another example was arranging quiet rooms for video-based work in hostel settings. Examples also included making allowances for therapy to take place from 'unorthodox' places like a client's car.

Other examples mentioned included practitioners making specific efforts to reach out to disadvantaged groups by networking with relevant stakeholders (criminal justice system, Traveller community, NGOs), updating online service features and social media information to reach more people and make access easier, and organisations seeking funding for teachers to provide basic digital skills training for the target groups they work with.

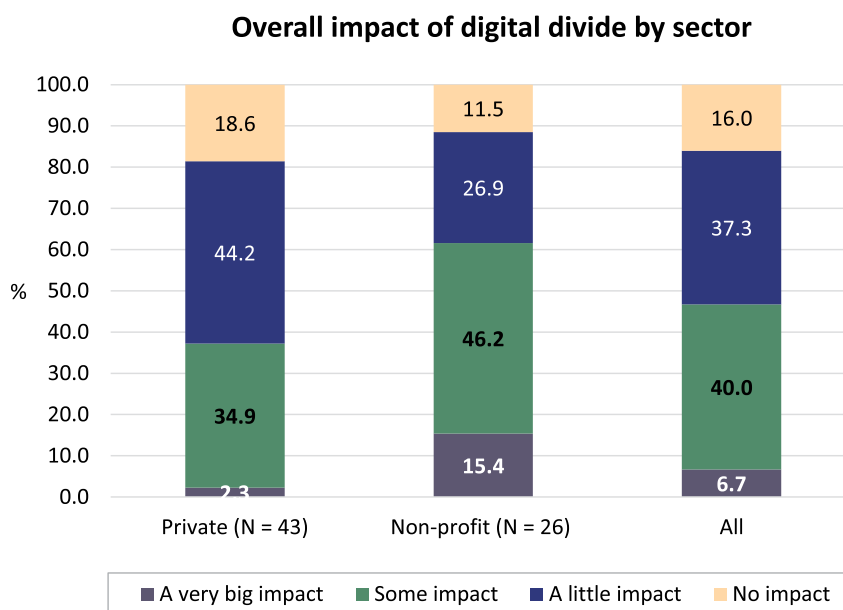
3.5 Overall impact of digital divides and what can be done about this

The survey also sought to gauge practitioners' views on the overall impact of digital divide factors on their work and what can be done at the wider ecosystem level to address this issue.

3.5.1 Overall impact

The survey asked practitioners about how much impact overall, if any, they felt digital divide barriers have on their ability to reach and effectively support the client groups they work with? Figure 3.11 presents the ratings given by the entire sample as well as separately for the non-profit and private practitioners.

Figure 3.11 Overall impact of digital divides on ability to reach and effectively support clients



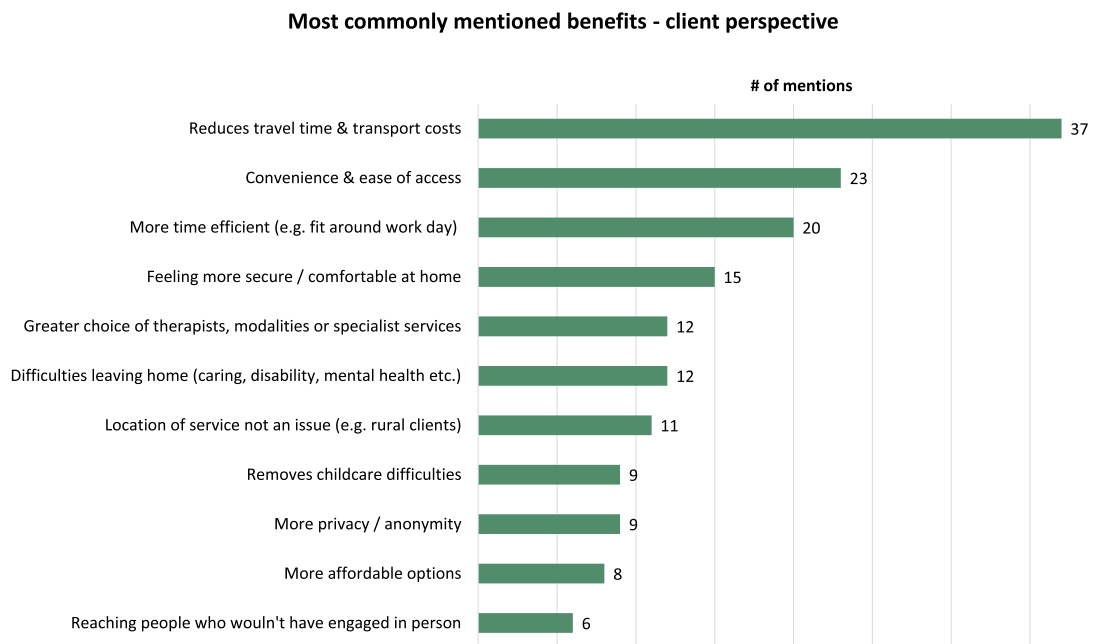
Results show that this is a substantial issue, with almost one-half (46.7%) of practitioners rating it as having more than a little impact. This was considerably more likely amongst non-profit practitioners (61.6%) compared to private practitioners (37.2%).

3.5.2 Benefits of remote consultations

To get a perspective on what might be the downsides of clients having difficulties to avail of remote consultations, the survey asked practitioners what they felt were the benefits of remote consultation from the client perspective and also from their own perspective as service providers.

Figure 3.12 shows a very extensive range of potential client benefits mentioned by practitioners. Reduction of travel time and transport costs was most frequently mentioned, as well as flexibility to fit in with everyday schedules. Overcoming particular barriers such as difficulties to leave home (due to childcare, disability, caring responsibilities, issues arising from mental health difficulties) was another commonly-mentioned area of benefit, as well as geographical barriers (e.g., for people living in rural areas far from services). Service quality benefits were also mentioned, including: greater choice of therapists, modalities or specialist services; feeling more secure at home; more privacy/anonymity, and reaching people who wouldn't have engaged in-person; as well as access to more affordable options.

Figure 3.12 Potential benefits of remote consultations for clients

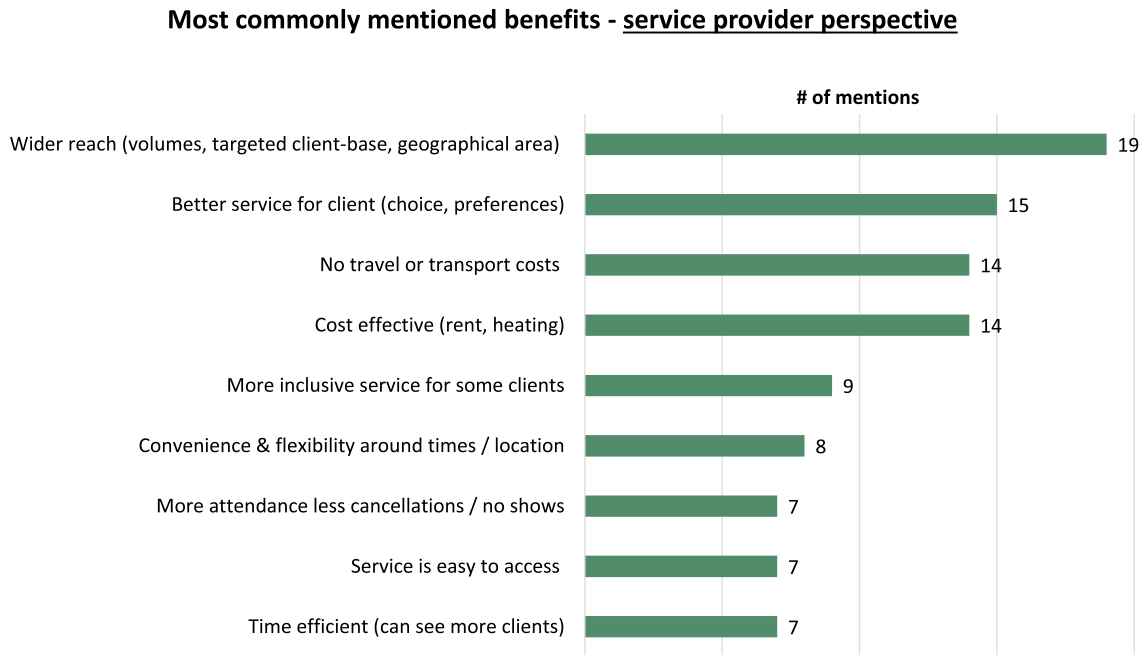


Other client benefits associated with accessing services through remote/digital channels were mentioned to a lesser extent:

- Giving clients more independence and a sense of control, less involvement needed from others.
- Early access, short wait times, out of hours and 'on demand' options.
- Less likely to meet or 'bump into' therapist socially or in local area.
- Can access service without experiencing poor weather conditions.
- If therapist is unwell, they can still provide therapy to medically vulnerable clients.
- Greater flexibility in rescheduling (if therapist doesn't have to coordinate use of limited therapy rooms).
- Offers flexibility to those in unstable environments.
- Possibility of access where there is coercive control.

Figure 3.13 shows the main areas of benefit mentioned from the service provider perspective. Wider reach was most commonly mentioned, including increased scale of potential client base, extending geographical reach, and opportunities to target particular client groups. Improved client experience was another area of benefit from the service provider perspective, including more choice and opportunity to meet client preferences and more inclusive and easier to access services particularly for some client groups (people with disabilities, social anxiety, prison inmates). A range of practice efficiencies were also mentioned, including a reduction in no shows, time efficiencies and flexibilities for practitioners, and practice overhead cost reductions. Other examples mentioned were less set-up time required between sessions (taking coats, getting water for clients) and easier to maintain sessions if the client or practitioner was away or unwell. Video platform features like 'screen share' can also enable easy shared viewing of resources during sessions and direct emailing of materials to clients.

Figure 3.13 Potential benefits of remote consultations for service providers



3.5.3 Actions that could be taken by actors in wider ecosystem

The survey also asked practitioners whether they felt various specific actions or initiatives would help to reduce digital divide barriers and increase access to online/digital mental health services. Figure 3.14 presents results for the overall sample and Figure 3.15 compares responses from private and non-profit sector practitioners.

Fig 3.14 Specific initiatives that could help to reduce digital divide barriers

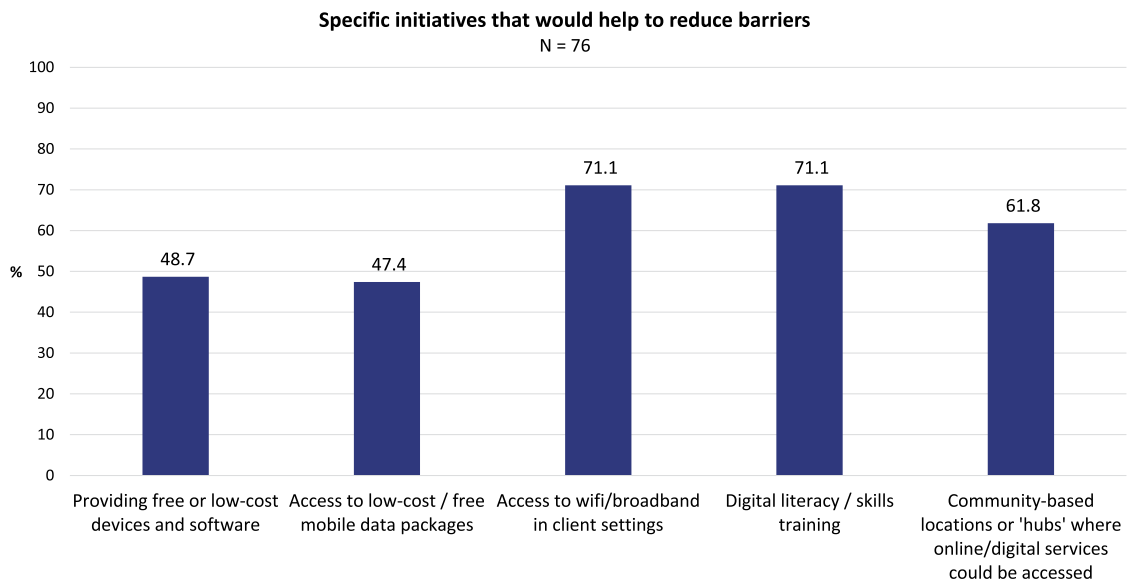
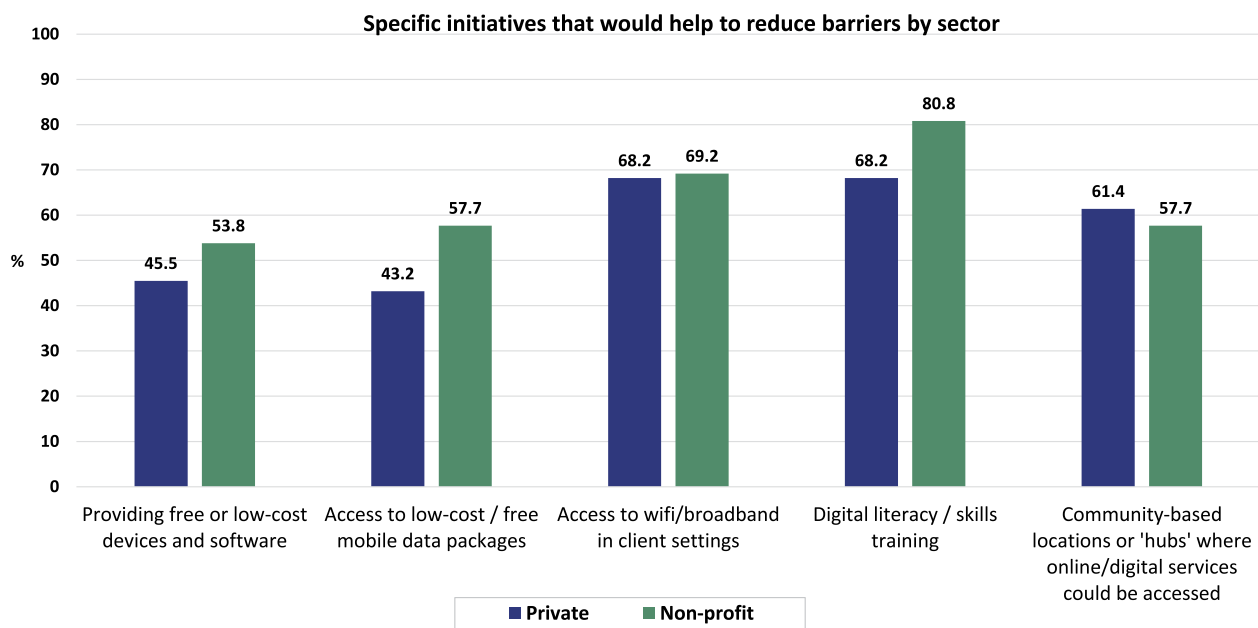


Fig 3.15 Specific initiatives that could help to reduce digital divide barriers - comparison of non-profit and private practitioners



An open-ended question was also asked on this topic, and some of these suggested solutions are detailed below.

More free and affordable mental health services

The need for increased funding, subsidised therapy and more free and low-cost mental health services was commonly featured in the responses. While these suggestions do not relate directly to digital divide barriers, practitioners considered them an important way of reducing barriers for potentially disadvantaged groups. Specific suggestions included subsidising private therapy, which could be enabled with a voucher system; offering a limited number of free therapy sessions per person per year; health insurance companies to reimburse clients for all counselling; and Government to fund longer-term counselling for unwaged individuals.

Increase access to private community-based spaces

Respondents had some concrete and practical ideas on how existing facilities and services could be utilised to provide community-based spaces where online/digital services could be accessed. Some of these suggestions included, enabling access through local libraries, social welfare offices or Family Resource Centres or leveraging existing 'remote hubs' currently available in many communities. Digital access could also be facilitated in specific situations like Direct Provision. Additionally, these community-based spaces could provide devices and connectivity as well as technical assistance and support.

Better broadband coverage and other telecoms initiatives

The continued roll-out of national broadband was considered important for those living in both rural and urban areas. Other suggested initiatives that could be implemented by the telecoms sector included scrapping data charges when accessing registered mental health services and toll-free telephone services for registered mental health services.

Culturally competent services and materials

Recommendations to help make services more culturally competent and accessible for people who speak a range of languages were also suggested. These included providing simple explainers about counselling/psychotherapy in multiple language; developing a specialised translator service; creating a database of therapists who work in other languages; and having a more culturally and ethnically diverse clinician workforce.

Promotion, information and training

Providing more information about available mental health services and promoting low cost/affordable options was also identified as a helpful solution. This could include information about how to access services and help to 'demystify' what is involved in psychotherapy, counselling and online therapy. Wider recognition that online is essential for some vulnerable groups (chronic illness, disabilities, caring responsibilities, unsocial work hours) was also deemed important. Training for those providing online services would be helpful as well as education for those in receipt of online services.

Making mental health services easier to access when needed

Specific suggestions were made to help ensure services were accessible to those who needed them, when they needed them. These included reducing waiting lists; hiring more therapists; creating one register of therapists to find a therapist quickly; and improving referral processes. Supported access was also recommended for online services i.e., a care worker or other individual who could be present to assist with connection and leave instructions.

Accessible and affordable technology

Technical solutions such as safe and low bandwidth online technology for non-profit organisations; adaptive technology for people with disabilities; and developing accessible video software where clients just need to 'click a link' to join sessions (e.g., no download required) were also identified as potential ways of making services more accessible.

3.6 Summary

Almost all practitioners reported having at least some remote consultations with clients during the pandemic. Going forward, a large majority plan to offer both options, just over one-in-ten plan to offer remote only, and a small number plan to only offer face-to-face consultations. Across all respondents, video consultations were most likely to be used a lot, with more than two-thirds reporting this. Just over one-third reported using phone consultations a lot, with very little reported usage of text consultation. Private practitioners were considerably more likely than non-profit practitioners to mainly utilize video consultations, with the latter reporting relatively more utilization of phone consultation. This may be an indication of cost sensitivities or other barriers to utilizing the more technologically-demanding video consultation option for non-profit sector services and their users.

Practitioners identified a broad range of potential benefits of remote consultations for clients. Among the more commonly mentioned were reduced travel time and transport costs; convenience and ease of access; time efficiency (being able to fit around work or other activities); feeling more secure/ comfortable at home; greater choice of therapists, modalities or specialist services; and the logistical benefits for those with difficulties leaving home (e.g., due to disability, caring responsibilities). Practitioners also mentioned a range of benefits from their own perspective, including wider reach across potential client groups and time and other efficiencies in their day-to-day work.

Many practitioners are already aware of digital divide factors and other disadvantages posing difficulties for client groups they work to avail of remote consultation options. Almost one-half rated this as having more than a little impact on their ability to reach and effectively support the client groups they work with, with this considerably more likely amongst practitioners in the non-profit sector compared to private practitioners. This would be expected given the likelihood non-profit practitioners have greater proportions of disadvantaged persons amongst the client groups they work with.

Older persons were most commonly mentioned as disadvantaged across the entire sample, especially due to their lower digital confidence and skills. Shared living arrangements were also quite frequently mentioned, including crowded households, young adults living at home with parents, people working from home, and congregate settings like direct provision with limited availability of quiet or private space. Parents with young families and lone parents were also specifically mentioned in this context. Lack of safety was another aspect, including situations with domestic violence, coercive relationships or other family difficulties. Challenges may also arise for people experiencing homelessness, in active addiction or living in other chaotic situations. Financial constraints arising from low income, including unemployed and people dependent on social welfare payments, were also quite commonly mentioned. Apart from costs of digital access, the sessional charges for using private practitioner services are also a barrier if not publicly subsidised.

The most commonly mentioned measure taken by practitioners themselves to reduce these barriers was to provide an in-person consultation option and/or choice of communication channel. Some also reported providing varying degrees of technical support/assistance to clients to help them utilise remote consultations and some reported addressing cost barriers in various ways (e.g., by covering the session connection costs).

The survey also asked practitioners whether they felt various specific actions or initiatives would help to reduce digital divide barriers and increase access to online/digital mental health services. Most commonly endorsed initiatives were those targeting access to wifi/broadband in client settings and digital literacy/skills training, followed by community-based locations/'hubs', provision of free or low-cost devices and software and access to low-cost/free mobile data packages.



Opportunities and barriers for specific groups



4 Opportunities and barriers for specific groups

This Chapter looks more closely at the circumstances and needs of a range of specific groups and examines digital mental health inclusion barriers and opportunities for each. The specific groups covered are:

- Migrants and refugees
- Travellers
- Prisoners and others under supervision of criminal justice system
- Blind / vision impaired
- Deaf / hard of hearing
- Homeless
- Older people
- Younger people
- People with ongoing / enduring mental health difficulties.

The evidence and analysis in the Chapter is mainly based on consultations with community and voluntary sector organisations working with the various groups, complemented with desk research by the research team. Within the scope of the exercise, there were only limited opportunities for direct consultation with user groups themselves and much more of this will be important going forward.

Many of the groups share common issues of relevance, including low income and other forms of disadvantage, limited digital and health literacy, and lack of access to suitable equipment and connectivity. The snapshots below aim to pick out and illustrate some aspects of particular relevance in each case rather than attempting to be exhaustive. Deeper and more extensive consultation with sectoral stakeholders, both service providers and users, would likely identify many additional issues and opportunities for leveraging digital mental health to address needs.

4.1 Migrants and refugees

Migrant groups, especially refugees and asylum seekers, tend to experience comparatively higher rates of mental health difficulties compared to host populations. For example, Irish data suggests that refugees and asylum seekers are ten times more likely to experience post-traumatic stress disorder (PTSD) compared to the general population (Wilson et al., 2013). Increased incidence of mental health difficulties may be associated with pre-migration experiences (e.g., war, trauma, torture) as well as post-migration factors (e.g., poor living conditions, reduced employment opportunities).

In the Irish context, people in Direct Provision (DP) are a particularly vulnerable group. DP is a reception system for asylum seekers awaiting the outcome of their international protection application, with some people remaining in this system for a number of years. The state provides communal accommodation (e.g., in a hotel setting), meals and a weekly allowance of €38.80 per adult and €29.80 per child. In 2022, approximately 11,400 people were in DP, over 2,800 of whom were children (Irish Refugee Council, 2022). Living in an environment like DP may exacerbate pre-existing mental health difficulties or contribute to the development of difficulties (Doras, 2020; Murphy, Keogh & Higgins, 2018). Attention to mental health issues for refugees and asylum seekers is important both during their time in DP and afterwards following movement to dispersed living.

Various reports and commentators have outlined inadequacies in current provision of mental health services for people in DP (College of Psychiatrists of Ireland, 2017; O'Connell et al, 2016). A particular problem is the need for people in DP to rely on generic mental health services in their centre's catchment area, and the absence of mental health services/programmes specifically targeting this sector and tailored to its needs. DP centres are anyway often in rural areas with limited transport options and reduced access to support services. Language, cultural differences when speaking about mental health, and a lack of familiarity with Irish health and mental health care systems may be barriers for migrants accessing mental health services.

Opportunities, barriers and potential solutions

Digital mental health approaches have considerable potential to help address these issues in various ways. Remote consultation options can help reduce barriers arising from rural location, lack of local mental health services, and limited transport options. As well as facilitating access to generic services in the wider catchment area, remote consultation models could also enable nationwide access to culturally competent practitioners and mental health services, available in a range of languages.

Teleconsultation models (e.g., telepsychiatry) can also enable provision of specialist support to local generic mental health services on mental health issues that may arise amongst asylum seeker populations, for example, survivors of torture or other severe traumas. Remote consultation options may be useful both for initial assessment on arrival as well as ongoing access to mental health care during the time resident in DP. Digital screening tools, for example tools for assessing potential PTSD, also offer potential for helping identify need and support triage/referral to appropriate services.

Digital mental health opportunities

Remote consultation can facilitate better access to mental health services in various ways, including:

- Reduce local barriers - DP centres often in rural areas with limited transport options and reduced access to support services.
- Nationwide access to culturally competent practitioners/services, available in a range of languages.
- Provision of specific mental health expertise (e.g., via telepsychiatry) to support local generic services.
- Applicable both for initial assessment on reception and access to services whilst in DP and afterwards.

Digital mental health screening/assessment tools may be very useful for particular issues such as PTSD:

- For initial assessment on reception.
- As needed whilst in DP and afterwards.

Refugees and asylum seekers are likely to experience many of the general digital divide barriers associated with socio-economic disadvantage, as well as a range of issues more specifically related to their circumstances. If not addressed, these will affect possibilities to access digital mental health services. These include lack of facilities at DP centres, limited access to devices and connectivity, and language and cultural factors.

Digital mental health inclusion barriers and solutions	
Barriers	Possible solutions
<p>Migrants/refugees/asylum seekers in general</p> <ul style="list-style-type: none"> • Privacy concerns regarding sharing personal information online. May relate to circumstances around migration or IP application. • Language and cultural barriers. • Some use of foreign phone numbers. <p>Direct provision</p> <ul style="list-style-type: none"> • Limited economic resources. Often payment delays when newly arrived in country. • Poor internet connectivity, particularly rural areas. • Overcrowding in centres, shared bedrooms, lack of private/confidential space to access services. 	<p>Migrants/refugees/asylum seekers in general</p> <ul style="list-style-type: none"> • Websites, mental health information and services available in different languages. Translation services available where required. • Directory of culturally sensitive mental health information, signposting and other tools (e.g. apps). <p>Direct provision</p> <ul style="list-style-type: none"> • Access to WiFi in DP centres. • Private and soundproofed room(s) available in DP centres for mental health service provision (online or in-person). • Provision of data packages, vouchers or devices for people newly arrived in country and awaiting payments.

4.2 Travellers

Travellers in Ireland face significant inequalities and experience higher rates of mental health difficulties and suicide compared to the wider population (UCD School of Public Health, 2010; McKey et al., 2020). Although Travellers make-up less than 1% of the overall population, 10% of young adult male suicides in Ireland are members of the Traveller community (McKey et al., 2020).

Mental health services do not generally gather data concerning ethnic identifiers which makes it difficult to accurately estimate the numbers of Travellers accessing services and supports. However, barriers such as a lack of culturally appropriate services and high levels of discrimination negatively impact engagement with mental health services (Quirke et al., 2020) and there can be strong stigma attached to mental health difficulties and help-seeking behaviours.

The National Office for Suicide Prevention (NOSP) funds a voluntary organisation (Exchange House) to provide the National Traveller Mental Health Service and individual therapy services are available in Dublin, Offaly and West Cork. The service is also currently developing a Traveller Youth Mental Health Service. A separate organisation – Traveller Counselling Service – provides face to face counselling in a number of locations, mainly in the Dublin region – and also established an online/phone counselling service during the COVID pandemic which has widened its geographical reach.

Opportunities, barriers and potential solutions

Experiences during the COVID 19 pandemic suggests remote consultation provides opportunities to expand the coverage of existing Traveller-specific mental health services nationwide. As well as extending the reach of current services, the anonymity and self-directed nature of some online offerings may reduce concerns around discrimination. Additionally, the 24/7 or 'out of hours' aspect of online/digital options may be helpful for those in crisis. More generally, it would be useful if mental health services gathered ethnic identifiers to understand who is availing of online services.

Digital mental health opportunities

- Nationwide access to Traveller-specific supports and culturally appropriate mental health services.
- The anonymity and self-directed nature of some online offerings may reduce concerns around discrimination.
- 24/7 or 'out of hours' aspect of online/digital options may be helpful for those in crisis.

Regarding barriers, Travellers are likely to experience many of the general digital divides associated with socio-economic disadvantage which affect possibilities to access digital mental health services, as well as a range of issues more specifically related to their circumstances. The percentage of permanent households without internet access is considerably higher amongst Travellers (59.9%) compared to the general population (18.3%) (CSO, 2016). As well as cultural factors, very high unemployment rates may be an important factor affecting this. Travellers living on halting sites also face particular barriers, including limited access to devices and connectivity.

Digital mental health inclusion barriers and solutions

Barriers	Possible solutions
<ul style="list-style-type: none"> • WiFi not a utility available on halting sites. • Reliance on one 'all you can eat' data package and hot-spotting to multiple devices in caravans. • Lower digital literacy and literacy levels. • Lack of private/quiet space in caravans. • Lack of trust and other cultural differences when accessing online supports. • Reluctance to share personal information online and fears around discrimination. Protecting young Travellers from online safety risks or potential discrimination. 	<ul style="list-style-type: none"> • WiFi made available on halting sites and greater access to free public WiFi networks. • Co-production of culturally appropriate online supports and information (e.g. Mind Your Nuck website). • Online forms and information accessible for a range of literacy levels e.g., plain English, 'listening mode' function, use of video resources or other mediums.

4.3 Prisoners and others under supervision of criminal justice system

People under supervision of the criminal justice system include people in prison and on probation, with large numbers going through each system annually. A majority of both groups are socially and economically disadvantaged in various ways. Recent reports have addressed aspects of the mental health situation of prisoners (Gulati et al, 2019) and those on probation (Power, 2021; Rooney, 2021). Both groups show a higher prevalence of mental health difficulties than the general population for severe mental health difficulties and for the more common mild to moderate conditions.

Mental health services for prisoners in Ireland have a number of components, including the Irish Prison Service (IPS) in-house Psychology Service and the Prison In-reach psychiatric services provided mainly by the HSE's National Forensic Mental Health Service (NFMHS). The IPS also funds an addiction counselling service provided under contract by Merchants Quay Ireland (MQI). Prison GPs have historically been the main access to primary care mental health supports.

In 2021, the total number of committals to prison was 6,133 involving 5,179 unique persons, and the daily average number in prison was 3,791 (IPS, 2022). Turnover in the prison population is substantial, for example, September 2022 had 520 committals (513 persons) and 498 releases (488 persons). Prisoners on remand/

trial accounted for 17.4% of the prison population and the sentenced prisoner population comprised 50.7% on sentences of 6 months or less, 27.5% on between 6 months and 2 years, and 21.7% on more than 2 years. Consideration of the possibilities offered by digital mental health may need to take into account issues around needs and rights of prisoners in these different situations.

The probation service worked with 15,400 offenders in the community over the year in 2021 (Probation Service, 2022). On October 1 2022 it had a total caseload of 11,374, of which 9,723 were in the community and 1,651 in custody (Probation Service, 2022a). The main categories of client in the community were: Probation Type Supervision: 3,904; Community Service: 1,787; Supervision in the Community Post Release from Custody: 1,632. Again, these dimensions of the service and its client populations may require consideration when examining the potential of digital mental health.

More generally, various reports on mental health service provision for prisoners have identified substantial pressures and unmet needs (e.g., IPRT, 2021; Mental Health Commission, 2021; Department of Health, 2022). Lack of capacity and long waiting times arise both for access to specialist (forensic) mental health services and for access to psychological services for the general prison population. Additionally, there are no dedicated mental health services or care pathways for people under supervision of the probation service (Power, 2021).

The Final Report of the High-Level Task Force to consider the mental health and addiction challenges of those who come into contact with the Criminal Justice Sector (Department of Health, 2022) identified many issues requiring attention to improve the current system. This includes 'throughcare' systems to ensure appropriate services are available at all points in the journey through the prison system and community mental health supports for those in non-custodial situations. It also draws attention to the need to ensure that prisoners have access to the same level of mental health services as the general population.

Opportunities, barriers and potential solutions

Consideration of the potential offered by digital mental health in this domain must be cognizant of the current under-development and under-resourcing of mental health services for the populations and settings concerned as identified in the reports mentioned above. Digital mental health innovations provide important logistical opportunities but need to go hand-in-hand with the broader investment and capacity-building required to put in place a modern, fit-for-purpose mental health system.

During the COVID-19 pandemic, both the IPS and NFMHS introduced remote provision of mental health services and the IPS also initiated some new access channels as part of its response to limiting infection spread in the prison system and supporting prisoners during a time of significant activity restriction (IPS Annual Reports for 2020 and 2021; IPS Psychology Service report, 2020). Examples include remote consultations, phone access from cells, in-cell TV programming, and some other developments with a contribution to prisoner mental health.

Although dedicated mental health services are not available for people under the supervision of the probation service, a recent report from the service identifies the digital mental health potential in probation service work (Rooney, 2021). For example, it refers to the potential of connected health technologies (text messaging, videoconferencing for individuals and groups, mobile apps, VR) for substance misuse supports and treatments.

The initiatives in the prison system during the pandemic show that digital mental health presents many opportunities for improving mental health service access for prisoners, and is relevant for all components of the ecosystem across the current mix of in-house, commissioned and in-reach services. This could contribute to addressing many of the recommendations in the report from the High-Level Taskforce on different aspects of the overall system – diversion, courts, community, and throughcare (Department of Health, 2022).

Digital mental health opportunities

- Potential to open up access to the community-based services available to the general population, for example to support continuity of care before/during/after prison.
- Improving prisoners' access to the IPS Psychology Service and to the in-reach NFMHS.
- Opportunities to establish dedicated mental health and substance abuse support services for people on probation.
- Provision of in-cell access to mental health information and psycho-education for prisoners.
- Development of mental health self-help supports for people on probation.

In principle, the logistical flexibilities of digital mental health open new ways of organising provision of mental health services for prisoners to enable more integration with the community services available to the rest of the population. Nevertheless, care should be taken to ensure that digital mental health approaches do not serve to further isolate prisoners from in-person engagement with mental health practitioners. Further development of the mental health system should therefore ensure expanded access to face-to-face services is to the fore, with digital approaches focusing on adding value and increasing choice rather than replacing further development of and investment in face-to-face services.

Both structural factors associated with prison regimes and general digital divide barriers arising from socio-economic disadvantage will influence the realisation of the digital mental health potential. For example, Education and Training Boards Ireland (ETBI) and IPS have highlighted the importance of digital literacy to equip prisoners with the competencies needed in modern society as well as for accessing learning opportunities (ETBI, 2022).

Digital mental health inclusion barriers and solutions

Barriers	Possible solutions
<ul style="list-style-type: none"> • Current capacity limitations of the mental health systems for prisoners, and lack of integration with community-based services. • Structural barriers and constraints arising from prison regimes, limiting access to technologies and how they can be utilised. • Disadvantaged backgrounds of the population concerned, including many with low education. • Low digital literacy and lack of access to opportunities to develop digital skills and experience in prison. • Lack of private/quiet spaces in prisons. 	<ul style="list-style-type: none"> • Modernisation of mental health care for prisoners, including provision of access to mainstream services available for the general population. • Continue to build on the innovations introduced during the pandemic, leveraging the logistical flexibilities of remote consultation and digital mental health. • Programmes to develop digital skills and digital mental health literacy amongst prisoners and probationers. • Development of a suite of digital mental health supports targeting prisoners and people on probation. • Expansion of the range of access points within the prison system (in-cell, private places, consultation rooms etc.).

Prison policies and practices on how mental health services for prisoners are organized intersect with broader aspects of prison regimes. These include prisoner access to communications devices and the prison system's control of external communication channels for prisoners, as well as the logistical requirements for escorting

prisoners to and from engagement with mental health services within prison and with external mental health services. Overarching framing conditions include the desired degree of integration and inter-working between prison and community services and how this relates to the rights of prisoners regarding equality of access to services.

4.4 Blind and vision impaired

According to census figures, 54,810 people have a sight related disability in Ireland, accounting for 1.2% of the total population (CSO, 2016), of which approximately 5% (2,750) are blind (NCBI, 2022). Estimates that take account of factors like under-registration and international prevalence rates indicate that this figure could be much higher (approximately 272,000 people in Ireland), with this number set to increase alongside population growth (Deloitte Access Economics, 2010). A substantial body of international evidence suggests people with vision impairments/blindness have increased risk of specific mental health difficulties such as anxiety and depression (Demmin & Silverstein, 2020). According to TILDA findings, 32% of respondents with poor eyesight had case level depression compared to 6% of respondents with excellent vision (O'Regan et al., 2011).

Online mental health services are often not accessible for people with sight loss or people who use assistive technologies such as screen readers. The first Digital Accessibility Index, commissioned by NCBI, showed that only one of twenty leading public and private hospital websites passed the accessibility test (Inclusion and Accessibility Labs, 2022). Many statutory providers of mental health services and their resources are not fully compliant with their legal obligations under the Web Accessibility Directive. Since 2020, all public sector websites must be fully digitally accessible. This requirement is being extended to all private providers by 2025.

Opportunities, barriers and potential solutions

Technology can help to remove barriers and create more accessible online services and supports for people with vision impairments/blindness. Many people with sight loss use assistive technologies such as screen readers and magnifiers. If adequately supported, these same tools could help to increase access to online mental health supports. Service providers can help to ensure that web content such as online mental health resources are as accessible as possible by adhering to guidelines such as the Web Content Accessibility Guidelines (WCAG 2.1 AA). For people with sight loss, audio can be a very accessible mode of support e.g., phone counselling, audio-heavy mental health apps. Other channels could be made accessible by ensuring compatibility with screen readers, magnifiers or include other features to customise text size.

Remote mental health consultations can remove barriers around transport and may be particularly beneficial for people building confidence with travel and mobility. Online access can also reduce the need to disclose that they are accessing mental health services, particularly for those who might need support travelling to or locating their mental health appointment. Remote access options also facilitate access to mental health and other supports specifically targeting people with vision impairments/ blindness by extending reach nationwide. New innovations such as online support groups for people with vision impairments/blindness (e.g., as offered by the charity Fighting Blindness) proved successful during the pandemic and can be an important source of information, advice or emotional support from people experiencing similar challenges. Accessible design and assistive technologies provide new opportunities to make information and psycho-educational materials equally available to people with vision impairments/blindness.

Digital mental health opportunities

- Remote access useful as an option to help avoid challenges people with vision impairments/blindness may experience with transportation and navigation; also, may be very useful for people who are building confidence with travel and mobility or have recently lost their sight; supports autonomy and reduces need to disclose to others that you are accessing mental health services.
- Facilitates access to mental health and other support services specifically targeting people with vision impairments/blindness.
- Online support groups for people with vision impairments/blindness can be an important source of information, advice or emotional support from people experiencing similar challenges.
- Accessible design and assistive technologies provide new opportunities to make information and psychoeducational materials equally available to people with vision impairments/blindness.

Many of the barriers affecting people with vision impairments/blindness accessing online mental health supports relate to accessibility. Often the platforms commonly used for video consultations and online meetings do not have adequate accessibility features or are not compatible with assistive technologies such as screen-readers. Online mental health resources (e.g., in PDF format) are often not compatible with screen-reading software if the document has not been made accessible and alternative formats (e.g., Word documents) may not be offered. It is worth noting that it is often the **self-guided** services / supports that access issues are most apparent in. As well as building-in accessibility in design of platforms and content, mental health service providers need an understanding of the issues for people with vision impairments/blindness and take these into account in arranging and conducting therapy sessions, group discussions and other programmes.

Digital mental health inclusion barriers and solutions

Barriers	Possible solutions
<ul style="list-style-type: none"> • Digital resources, apps, tools and websites are often not accessible for people with sight loss or who use screen readers. • Some video platforms and devices more accessible than others. • Frequent platform and software updates can present difficulties e.g., functions and shortcuts changing. • Video-conferencing may be costly or require a lot of bandwidth but not always needed; option to join with 'audio-only' not always available. • People may have other difficulties in addition to sight loss e.g., intellectual disability, reduced mobility, hearing loss etc. 	<ul style="list-style-type: none"> • Asking people about their communication preferences and accessibility needs and adapting to this (e.g., phone may be most accessible option). • Using video platforms with accessibility features (e.g., keyboard shortcuts), are compatible with screen readers and have 'dial in' option available. • Making materials available in different formats when requested e.g., Word documents instead of PDF. • Links to join online sessions may need to be emailed on the day or at a particular time so that they are easy to locate. • Arranging practice sessions to test platforms and different functions (e.g., mute, unmute, raise hand and keyboard shortcuts). In person support may be needed for this.

For mental health consultations, materials like therapy agreements should be made available in formats that can be read and signed easily, or services should offer accessible alternatives if this is not possible (e.g.,

verbally sharing information or recording consent/agreement). The accessibility of any given resource or service may be very individual or might depend on each person's level of vision. Therefore, a flexible, adaptive and responsive approach is likely to be the most inclusive.

4.5 Deaf and hard of hearing

Hearing loss is highly prevalent in older age, with more than 50 per-cent of adults over 75 years in Ireland reporting this (Canney et al., 2016). Experiencing hearing related difficulties may have a negative impact on mental health, wellbeing and quality of life. TILDA surveys of people aged 50+ found that 26% of respondents who rated their hearing as poor had case level depression compared to 8% of respondents with excellent self-rated hearing (O'Regan et al., 2011). Older adults in Ireland with hearing difficulties are also less likely to engage in active social participation and are more likely to experience symptoms of loneliness (Canney et al., 2016). Although there is an absence of Irish data examining the prevalence of mental health difficulties amongst people who are deaf or with hearing loss, a variety of factors are likely to contribute to higher levels of unmet need.

As well as many people with acquired hearing loss, the Deaf community in Ireland includes approximately 5,000 people who use Irish Sign Language (ISL) as their primary language (Chime, 2022). This community may face particular difficulties in accessing mental health services, including lack of access to specialist services, difficulties receiving an accurate diagnosis and different presentations of some mental health difficulties leading to misdiagnosis (Mental Health Reform, 2015). To ensure that services are equitable and effective, there is a need for practitioners with specialist knowledge of Deaf people with mental health difficulties to avoid misdiagnosis (du Feu & Chovaz, 2014). At a broad level, services and supports for Deaf people with mental health difficulties should be delivered in the person's preferred language and in a culturally appropriate way.

Digital mental health opportunities

Online approaches may open a range of opportunities to improve access to mental health services for people who are deaf or hard of hearing. Videoconferencing can be an accessible option for those who use signing or lip-reading and was used widely within the deaf and hearing-impaired community even before the onset of the pandemic. The widespread utilization of videoconferencing within mental health services since the pandemic may now present some new opportunities to increase access for these groups. Additionally, some digital mental health supports such as chat-based services may be particularly accessible for a range of hearing abilities. Adhering to web accessibility guidelines (WCAG) will also help to ensure remote and online/digital mental health services are accessible for people with hearing impairments.

Digital mental health opportunities

- Videoconferencing is a familiar mode of communication amongst Deaf community which has now been widely adopted by mental health service providers.
- Text-based supports and resources may be an accessible resource for people with a range of hearing abilities.
- Potential for accessible design and assistive technologies to alleviate barriers for both the Deaf community and people with hearing impairments; also, opportunities presented by video-relay and remote sign language interpreter services.

In principle, the use of videoconferencing could also expand the reach of specialist mental health supports for Deaf people, or increase access to culturally competent practitioners with ISL. Remote ISL interpreters (e.g., video-relay service (VRS), video remote interpreting (VRI)) could also facilitate increased access to mental health services, whether for in-person or remote consultations. The Irish Remote Interpreting Services (IRIS), for example, provides Irish Sign Language Interpreters via a Zoom video-call. However, remote interpreting may not necessarily be suitable where complex issues are being discussed, such as in a mental health setting, and its utilisation requires careful consideration (RISLI, 2021). For example, the presence of an interpreter in

a mental health consultation can impact on client-therapist rapport and the therapeutic relationship because of the involvement of a third party and the loss of nuance where the client and practitioner do not speak the same language.

Digital mental health inclusion issues – barriers and possible solutions

The following Table identifies some of the barriers and possible solutions for people who are Deaf or who have hearing impairments.

Digital mental health inclusion barriers and solutions	
Barriers	Possible solutions
<ul style="list-style-type: none"> Older people with acquired hearing loss may have lower digital literacy or less confidence engaging online. Platforms vary in accessibility features and providers of mental health services may not be aware of available features and how to use them. Use of features such as closed captions may be difficult in real-time when multiple voices are speaking (e.g., online group). Challenges associated with provision of mental health consultations for people who use ISL. 	<ul style="list-style-type: none"> Use of accessible devices, platforms and assistive technologies (e.g., closed captions, speech-to-text apps). Exploring the use of videoconferencing and remote ISL interpretation as a way of making services more accessible. Making materials available in different formats (e.g., ISL, text, video, images) or by adding captions/transcripts for audio material. The use of chat functions, lip-reading, body language and facial expressions in video sessions. Using 'mute' button to reduce background noise.

People who have acquired hearing loss in later life may have lower levels of digital literacy, or may be less familiar or comfortable with online modes of engagement. ISL users can experience a range of barriers to accessing mental health consultations, whether in face-to-face or remote modes; online access to ISL interpretation offers ways of overcoming this but may not always be appropriate. Accessibility features such as closed captions can be enabled on many videoconferencing platforms which will add captions/subtitles in real time, but service providers need to be aware of these features and know how to use them. Available platforms vary in the quality of their accessibility features and existing features may not always work well in specific situations, for example, in group settings (online group) where multiple people are speaking simultaneously.

4.6 People experiencing homelessness

As of October 2022, 7,917 adults and 2,480 children were accessing State-funded emergency homeless accommodation in Ireland (Department of Housing, Local Government and Heritage, 2022). However, these figures do not include those sleeping rough, in DP centres, domestic violence refuges, couch surfing, or homeless people in hospitals or prisons (Peter McVerry, 2022). The word homeless covers a broad category of visible (e.g., rough sleeping) and hidden situations (e.g., staying with friends/family because no other options are available) which may also present a variety of context-specific 'digital divide' related barriers.

Links between homelessness and mental health difficulties are often bi-directional - both addiction and mental health difficulties can be a casual factor or a consequence of being homeless, and often co-occur together. A systematic review and meta-analysis found about 27% of homeless people had PTSD, considerably more than the 3% reported in the general population (Ayano et al., 2020a). A review assessing the pooled prevalence of bipolar disorder among homeless people found an 11.4% prevalence amongst this group compared to estimates of about 1% in the general population (Ayano et al., 2020b).

Irish research has found high levels of depression, self-harm and attempted suicide amongst homeless persons

(O'Reilly et al, 2015). This includes an age-standardised incidence rate of self-harm 30 times higher among the homeless population compared with domiciled people in Ireland (2010-2104), as well as significantly higher likelihood of repetition of self-harm within 12 months of first presentation (Barrett et al, 2018). During a month-long study of an inner-city hospital in Dublin, over a quarter (28%) of the 109 psychiatry referrals received through the Emergency Department reported themselves to be homeless or living in temporary accommodation (Mcloughlin, 2021). Despite the high prevalence of mental health difficulties, people experiencing homelessness often encounter challenges or barriers accessing mainstream mental health services (Murphy et al., 2017).

Digital mental health opportunities

Digital mental health offerings could help reduce some of the barriers that homelessness may present for accessing mainstream mental health services (DeLaCruz-Jiron et al, 2023; Prince et al, 2022).

Digital mental health opportunities

- The logistical and other flexibilities may facilitate access for people without stable accommodation and open up new opportunities for mental health services to reach this underserved population.
- Specific applications such as signposting or enhancing social connectedness may be of particular benefit.
- Digital tools for early screening of highly prevalent mental health difficulties.
- Specialist in-reach to support frontline mental health services (e.g., through telepsychiatry).

The logistical and other flexibilities may facilitate access for people without stable accommodation and open up new opportunities for mental health services to reach this underserved population. Access to remote consultations, for example, could accommodate both scheduled appointments and unscheduled crisis interventions or other 'drop-in' type services. Approaches such as telepsychiatry also open up possibilities for specialist in-reach to support frontline homeless mental health services. Digital tools could also enable early screening for highly prevalent mental health difficulties to ensure early detection and referral to an appropriate service.

Digital mental health inclusion issues – barriers and possible solutions

Homeless people experience similar digital divide barriers associated with general socio-economic disadvantage as other marginalized groups, as well as particular circumstances associated with the lack of stable accommodation and the range of other difficulties of everyday life linked with homelessness. Nevertheless, homeless services in Ireland and elsewhere have shown during the pandemic that when these digital divide barriers are addressed it is feasible and valuable to provide digital mental health services for homeless people. The following Table identifies some of the barriers and possible solutions for people who are homeless.

Digital mental health inclusion barriers and solutions	
Barriers	Possible solutions
<ul style="list-style-type: none"> • Often reliance on mobile phones for online access because of lack of any other device; limited credit or data due to cost; some reliance on public WiFi networks. • Devices often lost or stolen. Phone numbers may change frequently. Lack of charging points for people sleeping rough or in tents. Costs associated with damage or maintenance of devices (e.g., cracked screens, water damage). • Privacy concerns in shared or congregated accommodation settings e.g., shared bedrooms, no private space available. • Some homeless services and accommodation based in older buildings which presents challenges for WiFi availability and coverage. • Lack of trust in online service and data privacy concerns. Some mistrust in loaned devices. 	<ul style="list-style-type: none"> • High speed WiFi provided in homeless accommodation and service settings. • Providing devices (e.g., tablets) to enable video consultations, or making access available in homeless accommodation settings. • Designated spaces or 'hubs' in homeless accommodation or other community-based locations. • Using accessible platforms that require lower bandwidth or no app download. • Linking with key workers and support workers who can provide in-person technical and logical assistance (e.g., booking rooms), help clients with set-up and provide reassurance and support.

Although evidence suggests there may be relatively high rates of mobile phone and smartphone ownership amongst homeless persons (Rhoades et al., 2017), there may be practical challenges to digital inclusion because of difficulties charging phones, risk of device theft or damage, and problems obtaining phone contracts without a fixed address. Additionally, for applications such as video consultations, mobile phones may not offer as good quality experience as larger-screen devices and, if wifi is not available, data usage costs on some mobile plans may be prohibitive for this form of usage. People staying in temporary homeless accommodation often lack the privacy required to engage in some forms of online mental health support (e.g., talking therapies).

4.7 Older people

Data from the TILDA survey shows the substantial prevalence of depression and anxiety amongst those aged 50 and over in Ireland. Amongst the participants, 13% reported clinically significant anxiety symptoms and 10% reported clinically significant depressive symptoms (Barrett, 2011). A further 29% report sub-threshold levels of anxiety and 18% report sub-threshold levels of depression. Factors that may contribute to these patterns include life changes (bereavement, retirement, etc.), social isolation, loneliness and having one or more chronic illnesses. Analysis of patterns within the older age population shows substantially higher prevalence of both anxiety and depression amongst older people in the lower wealth groups as well as amongst older people with hearing and/or vision loss. Data presented in Chapter 2 of this report also show that, relative to levels of mental health difficulties, older age groups are considerably less likely than younger age groups to utilize mental health services

Additionally, TILDA data indicates that almost one third of Irish adults aged 50+ experience emotional loneliness at least some of the time (Ward et al., 2019). Evidence is also available on the negative impacts on older people's mental health of social isolation for 'cocooning' or 'shielding' purposes during the COVID pandemic (Bailey et al., 2021; Ward & Kenny, 2020). The current Healthy Ireland programme specifically targets emotional and mental health difficulties amongst the older population as a priority area for attention (Department of Health, 2013).

Digital mental health opportunities

Older people may encounter barriers accessing in-person services due to reduced mobility, chronic health conditions, caring responsibilities or absence of services in their geographical locality. In rural areas of Ireland, there may be limited transport options available or long travel times making appointments more challenging to attend in person. Digital or other remote options may help to remove these barriers and create more accessible supports for older people. For example, easy access to counselling/psychotherapy programmes through videocall from home may open up new opportunities to address the substantial unmet need amongst older people, whether through ongoing usage of this channel or as an initial ‘ice-breaker’ to make it easy to take the first step.

Digital mental health opportunities

- Logistical benefits for older people in rural areas and/or who have reduced mobility, other chronic health conditions or caring responsibilities.
- Easy access to counselling/psychotherapy through videocall from home may open up new opportunities to address the substantial unmet need amongst older people; also, a potential ‘ice-breaker’ to make it easy to take the first step.
- Enables increased access to specialist supports (psychiatry of later life, dementia services, disability).
- Logistical and other flexibilities offer new ways for organisations supporting older persons to collaborate, for example, support organisations on the ground helping older persons directly connect with mental health services.
- Opens up new opportunities to provide psychosocial supports and help maintaining social ties in older age, through peer support or online support groups.
- Scalability of digital mental health and psychosocial supports can help in meeting increasing need as the ageing of the Irish population progresses.

Other digital opportunities accelerated during the pandemic can also facilitate nationwide access to specialist services for older people (e.g., specialist mental health / psychiatry of later life, dementia services, etc.). New opportunities to provide psychosocial supports and help maintaining social ties in older age (e.g., through peer support or online support groups) may reduce social isolation or loneliness and related negative mental health outcomes. The scalable nature of these types of supports may help to meet current and future levels of need in the context of an ageing population.

Digital mental health inclusion issues – barriers and possible solutions

Although the pandemic encouraged many older people to get online to keep connected with family and friends and to access services remotely, for substantial numbers of older people these remain unfamiliar modes of communication or ways of accessing services. Population level data shows that older age groups are still considerably less likely to use the internet than other age groups. Digital literacy as well as access to technology and connectivity is generally lower among older age groups. Cost issues are also a factor for many older persons living on tight budgets. Sensory or cognitive impairments developing in older age may also impact an individual’s ability to engage online.

Even before the pandemic, national programmes were in place to develop digital skills for older people and these continue to have an important role in reducing barriers and opening up new opportunities for older people to avail of digital services, including digital mental health. The pandemic also prompted organisations working with older persons in the community to begin providing devices (e.g., tablets) and help with connectivity, enabling maintenance of social contact and access to relevant services. One-to-one in-person engagement and support to help older people get set up and learn to use the equipment and services has been an important part of this.

Digital mental health inclusion barriers and solutions	
Barriers	Possible solutions
<ul style="list-style-type: none"> • Access to devices and home connectivity may decrease with age. • Lower levels of digital literacy. May not have personal email address which is often required for video sessions or when accessing services. • Lack of familiarity with different devices or platforms. Use of older device models which may not support software like Zoom, MS Teams etc. • Lower comfort levels or different attitudes towards technology. • Sensory or cognitive impairments which can develop in older age. 	<ul style="list-style-type: none"> • Provision of easy-to-use devices with relevant software pre-installed. • Help with connectivity and usage costs where required. • Digital skills training delivered with an in-person component. • Provision of help for initial set-up and connecting with mental health service; ongoing tech support after this, as needed for engagement with services. • Addressing accessibility issues arising for older persons due to sensory, cognitive and physical disabilities.

4.8 Younger people

International evidence suggests that around one-half of all mental health difficulties start by the age of 14 and three-quarters by age 24 (Kessler et al., 2005). Irish data indicates that levels of depression and anxiety in adolescents and young adults have been increasing in recent years (Dooley et al., 2019). Covid-19 has also had an adverse effect on young people’s mental health. Data from the Growing Up in Ireland survey (2021) conducted during the pandemic found almost one-half (48%) of 22-year-olds had elevated scores of depressive symptoms, an increase from 27% reported by the same cohort two years previously. In addition, the survey found that one-in-five 12-year-olds were in the ‘low mood’ group. In both age cohorts, young females had a higher prevalence of low mood and depressive symptoms.

A growing and varied range of online or digital mental health supports are available for young people (internet programs, apps, virtual reality environments, webchats, online peer support). A recent major review examined the evidence for digital health interventions amongst young people aged 10-24 years (Lehtimäki et al., 2021). The review found computerised CBT was effective for addressing anxiety and depression in this age group but the evidence for therapeutic video games, mobile apps, and social networking sites remains inconclusive. A lack of evidence exploring socio-economic background or low-resource settings was also noted.

Digital mental health opportunities

Young people in Ireland are now considered ‘digital natives’ and have grown up with technology as a normal mode of communication or way of accessing information. In a sample of almost 4,500 Irish children, 95% of 8–12-year-olds stated they owned a smart device and 34% said they could go online whenever they wanted to (CyberSafeKids, 2022). Children also seem to be getting access to the internet and becoming digitally literate from increasingly younger ages.

Young people from certain backgrounds or circumstances (socio-economic, geographical) may face a variety of barriers to accessing traditional, in-person services. In principle, digital mental health opens up new possibilities to better reach and support otherwise hard-to-reach or non-engaged younger people. The logistical and other flexibilities of digital mental health, and its scalability, provide opportunities to reach young people where they are at, and to design services and content in ways that fit with the circumstances and cultural/sub-cultural nuances of disadvantaged or otherwise vulnerable younger people.

Digital mental health opportunities

- Generation of 'digital natives' for whom online and digital channels are a familiar mode of communication; high levels of smart device ownership.
- Opens up many new opportunities for mental health services and supports to reach young people where they are at.
- Way of building rapport and trust with hard-to-reach/disengaged young people, and facilitate access for young people and families who may not typically attend in person services.

Digital mental health inclusion issues – barriers and possible solutions

A range of factors may impact on whether these digital mental health opportunities are realized. These include issues that cross-cut the younger age population in general as well as issues that may be more specific to disadvantaged or otherwise vulnerable young people.

Promotion of digital mental health approaches for children and young people needs to consider and take into account parental attitudes and concerns about online approaches and/or desires to limit 'screen time' and reduce access to devices. Online safety is becoming a growing concern amongst parents, services working with young people, and child protection agencies, and different age groups require tailored and age-appropriate education or safeguards to address this. To mitigate risks for young people, online mental health services should also consider 'safety by design' principles where possible. Instead of retrofitting safeguards and privacy controls, this approach places user safety as a fundamental design consideration from the outset. For some types of online engagements, young people may fear being overheard at home, particularly in situations where there are family difficulties.

Apart from these generic issues, some groups of young people may have unequal access to technology or may be particularly vulnerable to online risks due to socio-economic or other factors (Katz & Asam, 2019). Irish research on experiences around online learning for school children during the pandemic (Mohan et al, 2020) provides useful insights on issues also likely to affect inequalities in access to digital mental health services and supports. Relevant issues include number and types of devices available in a household, need to share limited bandwidth, and access to private spaces. Also, whilst young people from all backgrounds may be digital natives to at least some degree, current usage of digital mental health services is likely to vary across socio-economic groups both for young people and their parents. Cultural/sub-cultural factors are also likely to be important if service design and content is to be attractive for young people from disadvantaged or otherwise vulnerable backgrounds and for their parents where relevant. The following Table identifies some of the barriers and possible solutions for young people.

Digital mental health inclusion barriers and solutions	
Barriers	Possible solutions
<ul style="list-style-type: none"> • Unequal access to devices, connectivity, affordability of usage costs; opportunities for privacy at home, fear of being overheard by parent. • Parental attitudes may have impacts in various ways to encourage/discourage utilisation of digital mental health services and supports by young people. • Mental health literacy and digital mental health literacy likely to vary across socio-economic groups. • Online safety concerns require a lot of attention in this domain, and risks may be greater for children already vulnerable through factors linked to disadvantage or other circumstances. • For young people with complex needs, mental health is just one component of the required package of supports; siloed approaches may limit the possibilities for effective embedding of digital mental health. • Importance of retaining in person visits to the home environment of vulnerable children - important source of information for support workers or practitioners (e.g., family dynamic and atmosphere). 	<ul style="list-style-type: none"> • Programmes to support access to devices, connectivity and usage costs; also, availability of suitable places to access digital mental health services. • Digital skills, mental health literacy, and digital mental health literacy programmes for young people and parents. • Design of digital mental health services and content to resonate with different cultural/sub-cultural nuances (young people and parents); also tailored to age groups, attention spans and so on; co-production approaches have important role in this. • Developing blended/hybrid digital mental health models, combining in-person (and home visits where appropriate) and online/remote. • Collaborative approaches across services (mental health, schools, youth services) that combine inputs in ways that meet complex needs; logistical and other flexibilities of digital approaches offer opportunities to enhance this.

4.9 Ongoing and enduring mental health difficulties

Although much of the focus of digital mental health has been on ways of addressing the sheer scale of the challenges to meet treatment gaps and unmet need relating to common mental health conditions (e.g., mild-to-moderate anxiety and depression), there has also been growing attention to its role in supporting the very many people with more severe and enduring mental health difficulties (e.g., psychotic, bipolar and major mood disorders).

Evidence from a large-scale survey of mental health service users in Ireland found lack of access to psychotherapeutic and psychosocial supports was commonly reported (Mental Health Reform, 2019). Another frequently mentioned issue was not having continuity of engagement with a psychiatrist, and associated barriers to accessing effective and dynamic support for medication management.

Digital mental health opportunities

Experience during the pandemic has shown the role video-consultation can play in facilitating access to mental health services. The logistical and other flexibilities of telepsychiatry approaches open new opportunities for more frequent check-ins with mental health services (e.g., around medication management) as well as greater continuity of care through having ongoing access to the same psychiatric team. New innovations introduced during the pandemic such as ‘hospital at home’ and remote in-patient and out-patient offerings could now also be further developed or expanded on.

Some countries already have considerable usage of video platforms to enable bringing-in of real-time specialist

support (e.g., telepsychiatry) during consultations at primary care level (e.g., with a GP or other primary care mental health service). In the United States, the Veterans Health Administration has been providing video-enabled tablet computers to veterans with mental health care needs for a number of years. Research has found this appears to improve access to and continuity of mental health care services (Jacobs et al, 2019). Digital screening/assessment tools also offer opportunities at various points in the user journey, for example in identifying people who may be showing early signs of psychosis and linking them in with Early Intervention in Psychosis teams.

More generally, self-management interventions (e.g., information provision, active engagement in individual treatment plans, strategies to support medication or treatment adherence, symptom monitoring) can empower people with enduring mental health difficulties to develop skills for managing their own mental health care and recovery. A systematic review of self-management interventions for people with enduring mental health difficulties found benefits across a range of outcomes including a reduction in symptoms and length of admissions, and improvements in quality of life (Lean et al., 2019). These types of interventions can be delivered in an in-person setting, online, or by using a combination of these approaches.

A broader international review identified a range of technologies and applications in this field (Naslund et al, 2015). These include condition self-management and relapse prevention; promoting adherence to medications and/or treatment; psychoeducation, supporting recovery, and promoting health and wellness; and symptom monitoring. The review concluded these interventions were generally feasible and acceptable to users with serious conditions, but with more variable evidence on clinical outcomes.

Digital mental health opportunities

- Logistical and other flexibilities of digital mental health offer transformative potential in this domain.
- Remote consultations may enable better access to multi-disciplinary supports, improved continuity of care, increased access to specialist or psychiatry services, and so on; reaching people who find it difficult to leave home due to their mental health difficulty, other health difficulties or other factors.
- Digital/online applications can support greater involvement in own care (e.g. access to care plans, crisis plans or electronic health records) and can empower individuals and support self-management and personalised care.
- Can facilitate access to different forms of peer support including online support groups, forums, apps, social media.

Digital tools can empower individuals by providing more access to their own care plans, crisis plans, electronic health records or other tools that enable self-management (e.g., symptom monitoring or medication reminders). Peer support, which is considered an important element of recovery-orientated approaches, can be tailored to online modes of delivery. Different forms of peer support can be provided via digital channels including online support groups, web-based forums, and social media.

Digital mental health inclusion issues – barriers and possible solutions

The following Table identifies some of the barriers and possible solutions for people with enduring or ongoing mental health difficulties.

Digital mental health inclusion barriers and solutions	
Barriers	Possible solutions
<ul style="list-style-type: none"> Limited attention to applying digital mental health for this target group to date. Digital divides associated with socio-economic disadvantages due to reduced employment opportunities etc.; increased likelihood of limited digital skills. Specific factors linked to mental health difficulties may present barriers: <ul style="list-style-type: none"> symptoms related to mental health difficulty (e.g., hallucinations, difficulties concentrating, paranoia) may impact engagement with online services or platforms experiencing technical difficulties may further exacerbate symptoms or increase anxiety, people may forget previous digital skills when in a period of crisis mistrust in online services or concerns about data storage and privacy. Protecting anonymity and confidentiality in online settings (e.g., support group, peer groups). 	<ul style="list-style-type: none"> Awareness raising of the potential digital mental health offers in this domain. Provision of devices, IT skills training and connectivity to people with severe and enduring conditions; at any relevant point in their patient/client journey – inpatient, outpatient facilities, mental health services in community, and involvement with wider recovery supports. Providing technical support to people accessing services remotely if difficulties arise joining a session or appointment. Taking individual communication preferences (online or in-person) into consideration - may change over time or as symptoms change. Investment in digital mental health capabilities (technological and human resource) of mental health services (public and non-profit) and other services working with this population; includes IT infrastructure to streamline processes e.g., electronic health records, online portals etc.

At a general level, the impacts of severe and enduring mental health difficulties on employment opportunities may make this grouping more susceptible to digital divide barriers associated with socio-economic disadvantage. Co-morbid physical health conditions are also common amongst this groups, and may also impact on digital divide risks. Viewed from a mental health recovery perspective, digital exclusion can lead to a loss of social connectedness or empowerment, important components of mental health recovery (Middle & Welch, 2022). More specifically, a recent UK survey of 240 people with enduring mental health difficulties, found that just over two-in-five (42%) did not have basic digital skills (changing passwords, adjusting device settings, connecting to Wi-Fi network) and almost one-half (46.2%) did not have important skills for daily life such as online problem solving (Spanakis et al., 2021).

Some people with severe and enduring mental health difficulties may also experience barriers associated with aspects of their condition (e.g., fatigue, anxiety, difficulties concentrating, paranoia, hallucinations) that impact levels of engagement with online or digital services and compound digital exclusion. There may be a mistrust in online services including fears or concerns around being watched, monitored or recorded online, and people may seek a lot of information about data storage and privacy.

4.10 Summary

The analysis in this Chapter examined barriers that affect access to digital mental health for a range of disadvantaged or otherwise vulnerable groups as well as solutions that can reduce these barriers. It also identified a wide variety of opportunities to leverage digital mental health to positively address mental health needs of underserved groups.

Most of the groups covered are at higher risk of general socio-economic disadvantage and therefore at risk of the general digital divide barriers associated with this. Measures addressing access to devices and connectivity, costs and digital literacy/skills are therefore important. Additionally, these groups are also likely to experience more specific barriers associated with their circumstances and needs. Examples include lack of accessibility of digital mental health services for people with disabilities, language barriers, and challenges that aspects of mental health difficulties may pose for usage of digital mental health services. These can be addressed through designing and delivering services in ways that take account of the needs of the groups affected.

The logistical and other features of digital mental health also provide many opportunities to better reach these groups with mental health services they need. Examples include providing access from home for people with mobility or transport problems, remote in-reach services to congregate settings, and provision of nationwide access to culturally competent practitioners and services in a range of languages. Provision of increased access to specialist services targeting particular needs groups is another important opportunity area, for example, for people with sensory disabilities, refugees with severe trauma histories, and groups such as Travellers that experience higher risk of mental health crises and suicidality. The logistical and other flexibilities offered by digital mental health also present important opportunities to better support people with severe and enduring mental health difficulties through more continuity of care and empowering self-management and recovery.



Stakeholder roles in addressing digital mental health inclusion



5 Stakeholder roles in addressing digital mental health inclusion

This Chapter discusses sectoral roles and responsibilities in addressing digital mental health inclusion. Sections 5.1 and 5.2 examine the two sides of digital mental health inclusion - reducing digital divide barriers affecting access to digital mental health and leveraging the positive potential of digital mental health to reach groups under-served by traditional mental health services. Section 5.3 then presents a collation of initiatives from Ireland and other jurisdictions showing a range of approaches already implemented by a variety of stakeholders and at different levels of the ecosystem.

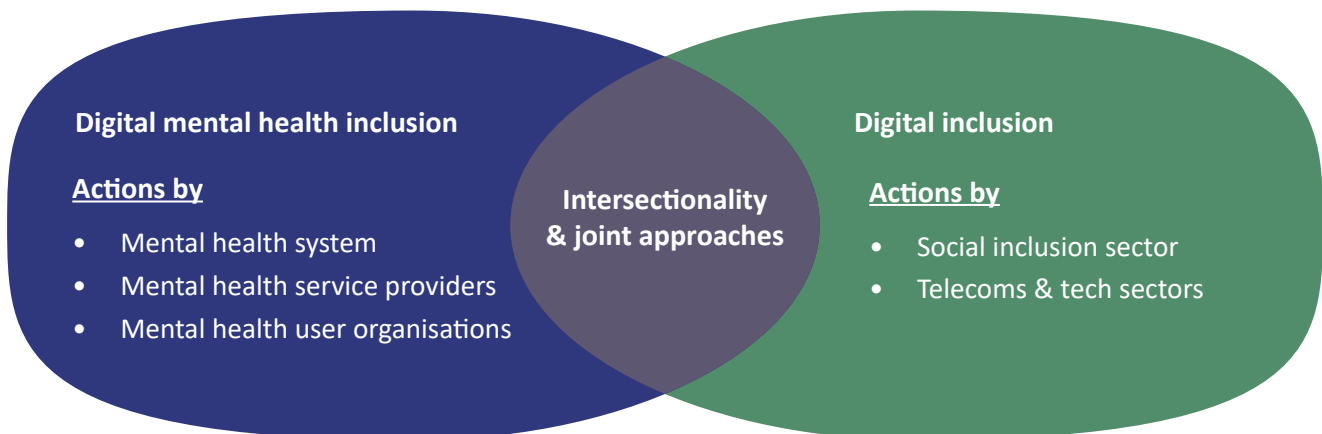
5.1 Reducing barriers

The evidence and analysis presented in Chapters 2, 3 and 4 as well as a wider trawl of activity in the field in Ireland and internationally indicates a number of important areas for attention in efforts to reduce barriers to digital mental health inclusion. For current purposes, this section groups these into four main areas for action:

- Users having the practical pre-requisites for access
- User skills, literacy and motivation
- Digital mental health services and tools designed to be inclusive
- Multi-modal access to mental health services, including non-digital options.

As illustrated in Figure 5.1, intersectionality is an important concept in this domain. The mix of solutions may include actions by players in the mental health sector (mental health system, individual service providers, and mental health user organisations), by other sectors with roles in addressing digital inclusion more generally (social inclusion; telecoms and tech industries), and through joint approaches targeting intersectionality in specific ways.

Figure 5.1 Sectors concerned



5.1.1 Mapping sectoral roles and potential ways of contributing

The following sections discuss the four areas for action outlined above and consider the potential roles and ways of contributing different sectors may have.

User practical pre-requisites

This dimension addresses the practical requirements at the user side to enable usage of digital mental health. They include connectivity, end-user devices and software, affordability, and having a suitable place to use digital mental health services. A range of approaches may be relevant for reducing barriers in these areas, including:

- Financial or in-kind supports for individual end-users
 - Connectivity (e.g., cost subsidies; mobile broadband dongles; free mobile data credit)
 - Devices & software (e.g., cost subsidies; provision of free devices)
- Collective access points for connectivity, devices/software, private space for digital mental health usage
 - Health and mental healthcare facilities (e.g., primary care centres)
 - Target group facilities (homeless, refugees, Travellers, etc)
 - Community facilities (libraries, Broadband Connection Points, etc).

Depending on the digital mental health usage circumstances, the mental health sector may have a direct role in addressing this area of action itself as well as through joint approaches with other sectors. Section 5.3 presents examples of both of these approaches.

User skills, literacy and motivation

This dimension addresses the skills and knowledge users require to effectively utilize digital mental health services. They include basic digital literacy and skills, mental health literacy, and digital mental health literacy and skills. The mental health sector has a core role and responsibility in promoting mental health literacy and digital mental health literacy and skills, as well as in promoting awareness and motivation in this domain.

Similar to the user practical pre-requisites dimension, actions to address this area might include programmes provided by the mental health sector itself and joint approaches between the mental health sector and other sectors. The mental health sector might consider development and delivery of digital mental health awareness and promotional campaigns, as well as providing or funding training programmes on mental health (and digital mental health) literacy and skills to develop user capacities to find, use and benefit from what's available through digital mental health services and supports. Joint/collaborative programmes and approaches with other sectors would also be very relevant, for example building-in mental health and digital mental health literacy modules in broader digital skills curricula and delivery programmes. Section 5.3 presents some examples of approaches in these areas.

Inclusive design

This dimension addresses digital mental health service design to ensure usability for all, including the medium of delivery, content design, and optimising compatibility with the devices and platforms users utilize for access. The mental health sector itself has a core responsibility for this aspect.

A range of media can be utilized for online/digital mental health services, including video, phone and text channels for therapeutic sessions and different forms of media content in mental health information and psychoeducation services (e.g., text materials, videos, voice narratives, etc.). Ensuring the media utilized cater for the needs of people with vision or hearing disabilities is an important consideration, and section 5.3 presents some relevant standards and guidance on this. Inclusive design should also cater for varying needs, capabilities and preferences across the wider population, including literacy levels, spoken/written languages, and cultural and sub-cultural nuancing.

Tech support services for users to help them utilize specific digital mental health services when required might also be included under this dimension (e.g., getting set up to connect to the services in the first place; making ongoing tech support available for users during usage). Section 5.3 presents examples of approaches by the mental health sector to address these aspects.

Multi-modal and multi-channel options

The three previous topics cover ways of reducing barriers to utilization of digital mental health so that

everyone has the potential to benefit from the opportunities it presents. Whilst actions in these areas are essential, it is also important to ensure that online/digital modes of service delivery do not become the only options available. In-person, face-to-face services will remain central to meeting needs for many people and many areas of mental health difficulty. Some people are unlikely to ever engage with online/digital mental health services (e.g., substantial numbers of the current cohort of older persons); some will prefer face-to-face options for some or all forms of engagement; the clinical suitability of online/digital or face-to-face modes may vary depending on client needs and context; and there may be therapeutic benefits for some people from having the opportunity to get ready for and go out to a face-to-face service.

Wherever possible and appropriate, users should have options to avail of a mix of ways to access mental health services and supports, including hybrid approaches that combine face-to-face and online/digital in flexible ways. In our research, some mental health service providers mentioned concerns about funders beginning to stipulate a single channel approach post-pandemic (only online or only in-person). This would be unhelpful from the digital mental health inclusion perspective.

5.1.2 Closer look at the mental health sector’s role and scope for action

Table 5.1 presents a framework for closer examination of the mental health sector’s role and scope for action in addressing digital mental health inclusion barriers and opportunities. The Table loosely distinguishes three usage contexts/relationships and suggests the degree of responsibility for the mental health sector across these. This is for illustrative purposes and other ways of looking at this topic may also be relevant and useful.

Universal: Ad-hoc utilization by the general population

This refers to on-demand utilization of services without a direct relationship between the user and service provider. Examples include mental health promotion and self-help through online information seeking and psychoeducation materials; and helplines/crisis support for the general population via phone, chat, text. The analysis suggests the strongest obligations for providers of these types of digital mental health service concern inclusive design as well as the broader issues around maintaining availability of non-digital options/channels. Knowledge of the range of needs across the population for inclusive design features is important for this, including user characteristics (e.g., disabilities), the range of access devices likely to be available, and the service design features required to cater for these. The mental health sector also has an important role to play in developing user skills/literacy across the population, especially mental health (and digital mental health) literacy.

Table 5.1 Illustrative mapping of mental health sector responsibilities for digital mental health inclusion actions

Dimensions of digital mental health inclusion		Digital mental health usage context		
		Universal General population (e.g., online info and mental health promotion)	Target group Specific target groups mental health services aim to better reach	Client Once-off or ongoing direct client-provider relationships
Reducing barriers	User practical pre-requisites	Low	Medium	Medium/High
	User skills, literacy	Medium/High	Medium/High	High
	Inclusive design	High	High	High
	Ensuring non-digital options	High	High	High
Leveraging the positive opportunities		High	High	High

Target group: Defined target group / population covered by mental healthcare system

This refers to defined target groups that mental health services aim to better reach, and wish to encourage digital mental health utilization for this purpose and ensure the option is available to all clients. In this case, the responsibilities of the mental health sector expand to include a greater role in ensuring access to the user practical pre-requisites. Section 5.3 presents some examples of approaches to digital mental health inclusion at this level, including a major programme developed by the Veterans Health Administration in the United States and some initiatives from England.

Client: Once-off or ongoing mental health care/support programme

This refers to digital mental health usage in the context of a direct relationship between a client and the service for a once-off episode of care or for an ongoing care and support programme. Once-off or time-limited programmes of mental healthcare might include a programme of therapy sessions or an intervention programme for an acute episode of more severe mental health difficulties. Ongoing, longer-term programmes of care and support may be in place for a client with severe/enduring difficulties, and include varying configurations of regular monitoring, medication review and broader recovery supports. The mental health sector has more extensive responsibilities around digital mental health inclusion for clients in either of these situations. Section 5.3 presents some examples of initiatives in this area from Ireland and other countries.

5.2 Leveraging opportunities

Chapter 4 profiled a range of target groups for digital mental health inclusion efforts and identified a wide variety of opportunities to utilize digital mental health to positively address mental health needs of these underserved groups. Table 5.2 below provides an indicative listing of just some of the opportunities identified across these groups.

Table 5.2 Illustrative listing of opportunities presented by digital mental health

Specific group	Opportunity area that could be leveraged to improve access to mental health services
Migrants and refugees	<ul style="list-style-type: none"> Nationwide access to culturally competent practitioners/services, range of languages. In-reach opportunities to provide more specialist services (e.g., trauma therapy). Reduce barriers to accessing local mental health services because of transport issues.
Travellers	<ul style="list-style-type: none"> Nationwide access to Traveller-specific and culturally appropriate mental health services. Anonymity and self-directed nature may reduce concerns around discrimination. 24/7 or 'out of hours' aspect of online/digital options may be helpful for those in crisis.
Prisoners	<ul style="list-style-type: none"> Potential to open up access to community-based services available to general pop. Support continuity of care before/during/after prison. Dedicated mental health and substance abuse support services for people on probation.
Blind / vision impaired	<ul style="list-style-type: none"> Avoid challenges they may experience with transportation and navigation. Access to mental health services specifically targeting people with vision impairments. Accessible design and assistive technologies to make MH supports more available.
Deaf / hard of hearing	<ul style="list-style-type: none"> Videoconferencing a familiar mode of communication amongst Deaf community Text-based supports/resources may be accessible for range of hearing abilities. Potential for accessible design and assistive technologies to alleviate barriers. Opportunities presented by video-relay and remote sign language interpreter services.
Homeless	<ul style="list-style-type: none"> Logistical flexibilities may facilitate access for people without stable accommodation and open new opportunities for mental health services to reach this underserved population. Digital tools for screening for prevalent mental health difficulties. Specialist in-reach to support frontline MH services (e.g., through telepsychiatry).
Older people	<ul style="list-style-type: none"> Logistical benefits for older people in rural areas and/or who have reduced mobility Video consultation from home may open new opportunities to address the substantial unmet need for mental health supports amongst older people. Enables increased access to specialist supports (psychiatry of later life, dementia, etc.).
Younger people	<ul style="list-style-type: none"> Generation of 'digital natives' – online/digital channels familiar mode of communication. Many new opportunities to reach young people where they are at. Way of building rapport and trust with hard-to-reach/disengaged young people & facilitate access for young people/families not typically attending in person services.
People with ongoing / enduring MH difficulties	<ul style="list-style-type: none"> Logistical and other flexibilities offer transformative potential in this domain. Remote consultations may enable improved continuity of care. Can support greater involvement in own care (e.g. access to care plans, crisis plans or electronic health records), empower individuals, support self-management. Facilitate access to peer support including online support groups, forums, etc.

The mental health sector clearly has a lead role in addressing the opportunities to better support these groups. This includes direct service provision by HSE mental health services as well as through HSE funding for voluntary and community sector mental health service providers working with these groups. Funding for other voluntary and community sector organisations that work with vulnerable groups would also be relevant to support their capacity to identify clients with mental health needs and connect them to appropriate services. Section 5.3 includes an example of a non-profit organisation working with older people that helps clients with mental health needs connect to online counselling and psychotherapy.

5.3 Examples of specific programmes and initiatives

This section presents a range of examples of specific programmes and initiatives from Ireland and elsewhere that address various dimensions of digital mental health inclusion (Table 5.3). They include large-scale actions at healthcare system level, smaller scale local initiatives by mental health services, and programmes delivered by the telecoms sector, as well as a range of other approaches and activities.

Table 5.3 Overview of the initiatives covered in this section

		Country	Sector/Provider	Details of the initiative
Access to devices & connectivity	1	US	Veterans Health Administration (VHA)	Digital Divide Consult: VHA social worker helps service users access funding for connectivity/equipment; Internet-Connected Devices: VHA lending of internet-connected devices.
	2	UK	NAVIGO (NGO)	Non-profit provider for people receiving NHS-funded mental health services – provision of 4G enabled tablets to clients during pandemic.
	3	UK	City and Hackney CCG	Personalised mental health budgets to help clients stay connected.
	4	UK	Mental Health Matters (NGO)	Non-profit provider of mental health and supported housing services – during pandemic provided pay-as-you go phones and training for clients
	5	UK	North East London NHS Trust	During pandemic – piloted videoconferencing room (hub) for clients to use when they lacked home equipment, private space, skills...
	6	UK	Imagine Independence (NGO)	Non-profit service provider – during pandemic adapted existing model of social prescribing to cover provision of devices on loan and training.
	7	UK	Good Things Foundation	National NGO-run social inclusion programme focusing on digital inclusion – provision of devices and data packages on large scale.
	8	IE	Migrant/refugee NGOs	Providing devices and connectivity (wifi dongles); vouchers to purchase mobile data packages from retailers; digital skills programmes.
Data charges, affordable usage	9	US	Health admin & Telecoms sector	VHA arrangements with large telecoms providers to help VHA clients avoid data charges when using VHA Video Connect on their networks.
	10	NZ	Health sector & telecoms sector	Sponsored Data initiative: National ‘zero-rated data’ programme providing access to health websites without data charges.
	11	IE	ComReg & telecoms operators	During pandemic (early stages anyway) – zero-rating of healthcare and educational websites for mobile data charges.
	12	US	Telecoms sector (FCC)	Rural Healthcare Programme; Affordable Connectivity Program.
Tech support	13	IE	Large mental health service	Dedicated IT support unit to facilitate clients utilising online/remote modes of inpatient and outpatient services, including hospital-at-home.
	14	IE	Vision impairment NGO	IT support service set up to help service users get online (via Zoom) and access online support groups and other services.
	15	IE	Older persons NGO	Connecting older persons to online counselling.
Inclusive design & accessibility	16	IE	Travellers NGO	Co-design to develop Young Pavees ‘Mind Your Nuck’ website.
	17	UK	Leeds Office of West Yorkshire ICB	Co-design based on workshops with people who use services, carers and people working in mental health services, adult social care, and others.
	18	NZ	National telemental health service	Co-designed with at-risk groups & providing specific pathways for these groups.
	19	Global	WHO and Telecoms Sector (ITU)	Global standards/guidance on accessibility of telehealth services; has section on requirements for persons with mental health difficulties.

The following sections provide more details on these various initiatives, organized according to the sectors/providers involved (the relevant initiative number from Table 5.3 is in square brackets).

Veterans Health Administration (VHA)

A number of the examples listed in Table 5.3 are from the Veterans Health Administration (VHA) in the United States. The VHA illustrates an extensive, proactive approach to digital health/mental health inclusion by a healthcare system. Exhibit 5.1 presents some of the features of the programme, including in-house programmes it funds itself and/or specific linkage to programmes funded by telecoms sector.

Exhibit 5.1 Veterans Health Administration (VHA)

The VHA Telehealth programme provides a number of supports to ensure digital divide barriers do not prevent veterans access the wide range of telehealth (and telemental health) services they provide. Elements include:

[1] Digital Divide Consult & Lending of Internet-connected Devices

Digital Divide Consult: This component targets clients who might benefit from telehealth but don't have internet access or a video-capable device. Through a Digital Divide Consult the VA provider can refer the client to a VA social worker who will help determine their eligibility for programmes to help get the connectivity or technology needed for telehealth. The Federal Communications Commission (FCC) has a number of telecoms sector programmes of potential relevance, including Lifeline and the Affordable Connectivity Program (ACP).

Internet-Connected Devices: Through this component, VHA can lend the client an internet-connected device to enable them utilize VA telehealth services. The Digital Divide Consult can help determine eligibility. This is a largescale programme in operation since 2016, with emerging evidence of positive impacts through increased mental health care access, continuity and efficiency (Jacobs et al, 2019).

[9] Mobile Connectivity Support for Telehealth:

VA have arrangements with a number of large telecoms service providers to help VA clients avoid data charges when using VA Video Connect on their networks. This enables VA clients to utilize telehealth with fewer worries about data charges.

Further information: <https://telehealth.va.gov/digital-divide>

A range of mental health sector initiatives from England

The NHS Confederation has produced a guidance document on 'Digital inclusion in mental health - A guide to help increase choice and improve access to digital mental health services' (NHS Confederation, 2020). This provides advice and insights that may be useful in the Irish context as well as a range of examples of how the COVID-19 pandemic prompted mental health sector initiatives addressing digital inclusion in mental health. Exhibit 5.2 profiles some of these.

Exhibit 5.2 Mental health sector and other initiatives from England

[2] Digital inclusion assessment and dashboard to identify clients needing connected tablets

NAVIGO is a non-profit provider of integrated mental health and social care services for people receiving NHS-funded care in North East Lincolnshire. During the pandemic they moved rapidly to provision of appointments by video conferencing. As part of this they developed a digital inclusion patient questionnaire and a results dashboard. The questionnaire asked about access to technology, training needs, contact preferences and internet connectivity. The dashboard supported sourcing of funding to purchase tablets with 4G enabled, and provided information on needs so local services could target provision of the tablets to people who were digitally excluded and desired to use technology to engage with their services.

[3] Personal mental health budgets for digital inclusion

This initiative by City and Hackney Clinical Commissioning Group (CCG) used personalized health budgets to increase digital inclusion. Before the pandemic the service had already introduced a new approach comprising personalized care and support planning, linking to activities in partnership with third sector organisations and Personal Health Budgets (PHB). During the pandemic the service introduced a 'Stay Connected' offer through PHB to support digital inclusion for people with lack of access to equipment and/or connectivity. This enabled quick access to a choice of mobile phones and/or sim cards for utilization of remote support services as well as community activities online and keeping in touch with family and friends.

[4] Digital services in supported housing

Mental Health Matters (MHM) is a non-profit organisation providing a range of mental health services and supported housing options, including floating support, for people with mental health difficulties in the North-East and Midland areas. During the pandemic, all except their residential services moved to remote provision. For the floating support service, an assessment process identified people without access to a mobile phone, tablet or computer. MHM purchased pay-as-you-go phones for those with no existing means of contact and staff provided support/training in how to use them. The phone enabled regular contact with support or recovery workers, and apps were installed to help people maintain contact with family/friends.

[5] Digital hub to provide clients with access to videoconferencing facilities in a private space

During the pandemic North East London NHS Foundation Trust introduced a range of digital services for remote access. As part of this, it piloted a videoconferencing room (hub) that clients and staff could use when they lacked access to home equipment, private space, or skills. Operational issues addressed included ways for staff to provide technical support for clients, security issues regarding log-in to the device and ensuring no data is stored on it, and selecting easy to use videoconferencing software.

[6] Social prescribing for digital inclusion

Imagine Independence is a non-profit organisation supporting people with physical or mental disabilities to live full independent lives. During the pandemic they adapted their existing model of social prescribing for physical needs to cover support in the digital space. This included provision of devices on loan, linking people with training and other community supports, and connecting with volunteers for one-to-one support. The initial aim was to support connection for social purposes but other benefits were anticipated to emerge, such as remote access to mental health services and supports.

[7] Good Things Foundation

The Good Things Foundation is a leading UK digital and social inclusion charity. It brings together community partners and other relevant stakeholders such as telecoms/tech sectors and has collaborated on different projects with the NHS. Core lines of activity include: **Online Centres Network** of community partners who provide digital access and skills in local communities across the UK; **National Databank & National Device Bank** providing free SIMs and mobile data donated by mobile operators and refurbished digital devices.

Further information: <https://www.nhsconfed.org/publications/digital-inclusion-mental-health>

Well-developed tech support services for users of specialist mental health services (Ireland)

A large Irish non-profit provider of specialist mental health services developed a dedicated IT support unit as a key component of online/remote modes of in-patient and out-patient service delivery initiated during the pandemic (Exhibit 5.3). This includes new innovations such as a ‘hospital-at-home’ offer.

Exhibit 5.3 IT support services for users of specialist mental health services (Ireland)

[13] IT support unit for service users, including hospital-at-home as alternative to inpatient care

The pandemic led to the establishment of a dedicated IT support unit within a large specialist mental health care provider in Ireland. This was primarily in response to the implementation of online/remote modes of in-patient and out-patient service delivery and new innovations such as a ‘hospital-at-home’ offer during the pandemic. The unit provides a range of IT supports to people accessing in-patient and out-patient services and at different stages of their care. It can assist or answer technical queries regarding the online patient portal system which stores electronic health records as well as provide ‘in-the-moment’ troubleshooting support if any difficulties arise for clients trying to join video-enabled appointments. One of the key success factors of the approach is the individualised, tailored and case-by-case approach to supporting clients.

As a first step, a phone call is arranged with new admissions and new referrals to ensure they are in a position to access services online/remotely. The unit then supports clients to get set up with the necessary technology and skills to access online appointments or services. This support might include setting up devices with the required apps or providing tablets to people accessing in-patient services. The service also developed a communication preference questionnaire which is completed during the intake process to capture how people accessing their services would like to be contacted (email, phone, postal communication). As communication preferences may change during the care journey, clients can update this information if and when they wish.

Standards for telehealth accessibility

Prompted by the increased importance of telehealth since the pandemic, WHO-ITU launched their ‘Global standard for accessibility of telehealth services’ in 2022 to provide detailed guidance on how to ensure accessibility for people with disabilities (Exhibit 5.4). These standards include requirements to address needs of persons with mental health difficulties.

Exhibit 5.4 WHO-ITU Global standard for accessibility of telehealth services

[19] These standards provide detailed guidance on how to address accessibility in telehealth services to meet the needs of people with various disabilities, and also provide specific requirements to address needs of persons with mental health difficulties:

Requirements for persons with mental health conditions and psychosocial disabilities:

- avoid unexpected, irrelevant, and inappropriate content that can be upsetting and trigger negative feelings and reactions
- explain the measures implemented to ensure that usage and data remain safe, private, and secure in effort to avoid negative thinking regarding the possibility of related undesirable consequences
- avoid using complicated user interfaces and language that are difficult to understand and providing inadequate guidance on how to complete tasks
- avoid unnecessarily effortful tasks and allowing malfunctioning features to persist
- avoid presenting low-quality information as this contributes to distrust.

Further information: <https://www.who.int/publications/i/item/9789240050464>

Initiatives by the non-profit sector in Ireland to provide connectivity, devices, skills and tech support

Consultation with voluntary and community sector organisations identified a range of measures to provide connectivity and devices and develop skills targeting particularly disadvantaged individuals or groups. Exhibit 5.5 outlines examples of actions taken by organisations working with migrants/refugees/asylum seekers, older persons, and blind/vision impaired persons.

Exhibit 5.5 Initiatives for migrants/refugees/asylum seekers, older persons, people with vision impairments

[8] Migrants/refugees/asylum seekers

A number of voluntary and community organisations working in this sector have addressed various aspects of digital inclusion with direct or indirect relevance for digital mental health inclusion. One organisation supporting families in direct provision spoke about providing devices and connectivity to particularly excluded families and those who needed to access mental health supports through remote channels; another mentioned giving vouchers (e.g., 'One4all' gift cards) to migrants to utilize to purchase mobile data packages from retailers. More generally, organisations in this sector often offer drop-in services where migrants can get IT support on an informal basis, including assistance with online applications, setting-up email addresses and navigating services with limited English or digital literacy. A range of broader training programmes also address IT skills for these target groups. AkiDwA piloted a 'Door to Work' project aiming to increase employment opportunities and training for migrant women in the Greater Dublin area with sponsorship from PayPal enabling purchase of tablets, related equipment, and dongles for the 27 women participating in the project. SaorEd is an online platform that provides free access to education and training courses for people from refugee and migrant backgrounds and is a joint initiative between Doras, New Horizon, and Dignity Partnership. Training offered includes English language courses, information technology (IT) skills, healthcare, and career preparation courses.

Further information: <https://saored.com/>

[14] People with vision impairments

During the pandemic, an Irish organisation supporting people with vision impairments developed an IT support function in the context of their new online support groups for the target group. Many of their client base were not familiar with video conferencing platforms and a member of the counselling administration team supported 500 people to get online by talking them through how to use Zoom, sending on links, or by providing information about assistive technologies. This support was generally on a 1:1 basis and tailored to each individual's needs and digital literacy level. Practice sessions were arranged for people to become familiar with joining video sessions or to trial different functions (mute, unmute, raise hand etc.) and keyboard shortcuts. Real-time telephone support was available for people having difficulties accessing online support groups.

[15] Older persons

ALONE is a large organization providing support coordination and other services for older persons across Ireland. It has been developing its range of technology-based supports over the years. During the pandemic, the organization worked to help older people to remotely connect with services and with family/friends. This included provision of devices (smartphones or tablets) pre-loaded with relevant applications and support to get connected for older people who did not have these already. Devices came from donations from the tech industry. An ALONE tech support team identified older people who would benefit and helped them get set up and connect to services of relevance. More recently, ALONE is involved in the VideoConnect project in collaboration with Mental Health Reform and Helplink Mental Health, which is helping older persons with mental health needs to connect with online counselling/psychotherapy services.

Further information: <https://alone.ie/our-work/#Technology-Community-Supports>

Affordability of telecoms costs for telehealth users

Exhibit 5.6 presents some examples of approaches to ensure affordability of telecoms for telehealth users. This includes telecoms/electronic comms sector approaches from the US and Ireland, as well as joint initiatives between the health and telecoms sector in New Zealand.

Exhibit 5.6 Telecoms/electronic comms sector supports for digital health inclusion

[10] Sponsored Data Initiative – New Zealand

The Sponsored Data initiative allows the public in New Zealand to access health-related websites without incurring mobile data charges. This 'zero-rated data' scheme is available for pre-pay accounts and those on monthly plans on particular telecoms networks (Spark, Skinny, Vodafone, 2degrees, Slingshot or Orcon). The initiative aims to ensure people across socio-economic groups can access websites that provide health (and mental health) information and access digital health services. Costs are charged to New Zealand Health, the organisation coordinating the health system in the country.

[11] Telecoms industry commitments to assist customers during COVID-19 pandemic (Ireland)

In April 2020, ComReg announced an initiative with telecoms operators to assist customers during the COVID-19 pandemic. Commitments made by the participating operators included one directly relevant for digital mental health inclusion - access to healthcare and educational resource websites identified by the Government will be zero-rated for all customers where technically feasible. Other commitments to enable people to access higher bandwidth services at affordable costs also have relevance - any fixed broadband customers who do not have unlimited usage already as standard will be given the opportunity, if they require, to upgrade their package (which may be on a temporary basis), with their current service provider; any customer who does not have fixed broadband and who relies solely on mobile access to the Internet will have the opportunity to avail of affordable unlimited mobile data access/package from their service provider.

Further information: <https://www.comreg.ie/media/2020/04/ComRegPressReleaseR15April20.pdf>

[12] Federal Communications Commission (FCC) – United States:

The Federal Communications Commission (FCC) has implemented a number of relevant programmes over the years, some pre-dating COVID-19 and others introduced in response to the pandemic.

Rural healthcare programme: Financed from a universal service fund levied on telecoms network providers.

The Healthcare Connect Fund Program, established in 2012, provides support for high-capacity broadband connectivity to eligible health care providers and encourages the formation of state and regional broadband health care provider networks. Under the Rural Health Care Program, eligible rural health care providers, and those eligible non-rural health care providers that are members of a consortium that has more than 50 percent rural health care provider sites, receive a 65 percent flat discount on an array of communications services.

The Telecommunications Program, established in 1997, subsidizes the difference between urban and rural rates for telecommunications services. Under the Telecommunications Program, eligible rural health care providers can obtain rates on telecommunications services in rural areas that are reasonably comparable to rates charged for similar services in corresponding urban areas.

Affordable Connectivity Program: The Affordable Connectivity Program is an FCC benefit program that helps ensure that households can afford the broadband they need for work, school, healthcare and more. The benefit provides a discount of up to \$30 per month toward internet service for eligible households and up to \$75 per month for households on qualifying Tribal lands. Eligible households can also receive a one-time discount of up to \$100 to purchase a laptop, desktop computer, or tablet from participating providers if they contribute more than \$10 and less than \$50 toward the purchase price.

Further information: <https://www.fcc.gov/acp>

https://www.fcc.gov/sites/default/files/the_fccs_universal_service_rural_health_care_programs.pdf

Co-design approaches for accessible and culturally appropriate mental health services

Co-design with target groups and stakeholder involvement can help create digital mental health solutions that are acceptable, accessible and culturally appropriate. Collaborating with community and voluntary sectors who have the knowledge and cultural sensitivity to engage with disadvantaged groups can be an integral factor in this process. Exhibit 5.7 provides examples of co-design approaches used to create inclusive mental health websites.

Exhibit 5.7 Co-designing mental health websites with target groups

[16] Young Pavees 'Mind Your Nuck' website (Ireland)

This website provides culturally appropriate information on topics impacting young Travellers' mental health such as racism, discrimination, drug issues and unemployment as well as offering signposting to services. Focus groups with young Travellers informed development, in partnership with Pavee Point, including the website name 'Mind your Nuck' – nuck means 'head' in Traveller language. Co-design ensured inclusion of features to increase the website's appropriateness and accessibility. Literacy was identified as a barrier for young Travellers so each webpage has an ear icon the user can click to have the information read aloud in a Traveller voice.

Further information: <https://youngpavees.ie/>

[17] Mindwell website (UK)

Thrive by Design is a collective of specialists in inclusive co-design based in the UK. As part of their work, they supported the co-design of the Mindwell website which is a 'go to' mental health resource for people in Leeds bringing together information from the NHS, Leeds City Council and the local community and voluntary sector. The website was developed through co-design workshops with people who use services, carers and people working in mental health services, adult social care, the charity sector, libraries and businesses. Based on feedback from co-design sessions, content on the website can be translated into over 100 languages and British Sign Language is also available.

Further information: <https://www.mindwell-leeds.org.uk/>

[18] Whakarongorau Aotearoa (New Zealand Telehealth Services)

This social enterprise runs the Government-funded free to access, 24/7 national telehealth services across seven digital channels including voice, webchat and text. In the 12-month period leading to June 2022, Whakarongorau Aotearoa responded to over 5.7 million contacts involving 2.7 million people. A range of 'virtual' mental health services are hosted on the platform, including brief intervention counselling, peer support, after-hours support, supports for young people with depression and anxiety and helplines for different difficulties such as depression, gambling and addiction.

Priority groups such as Māori and Pacific people and those living in disadvantaged communities are central in the design and delivery of Whakarongorau Aotearoa services. Digital services are co-designed with at-risk groups and specific pathways have been developed for people who identify as Māori, Pacific or as having a disability, helping to ensure service provision is culturally sensitive and appropriate.

Efforts have been made to grow and sustain a culturally competent workforce which includes embedding student placement programmes to support Māori and Pacific students. Almost 30% of the 'Healthline' (general health advice and information helpline) workforce identifies as Māori or Pasifika. Across all telehealth services, frontline staff can speak 30 languages and interpreter services are available for over 300 languages.

Further information: <https://whakarongorau.nz/>

5.4 Summary

This Chapter examined sectoral roles and responsibilities in addressing digital mental health inclusion. The focus was mainly on identifying what actions may appropriately fall within the remit of the mental health sector itself, but also gave some attention to ways that other sectors such as telecoms and broader social/digital inclusion can play a role in this domain.

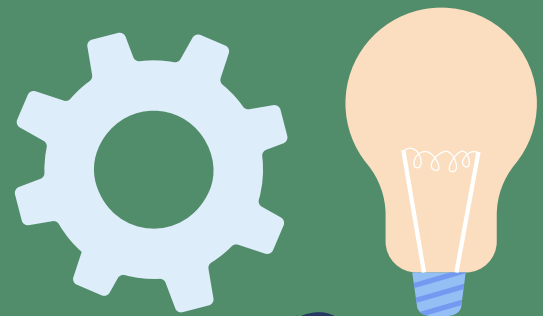
Regarding reduction of barriers to digital mental health inclusion, the analysis focused on four areas – users having the practical pre-requisites for access; user skills, literacy and motivation; digital mental health services and tools designed to be inclusive; and ensuring multi-modal access to mental health services and supports, including non-digital options. The mental health sector’s role and scope for action in these areas may vary depending on the mental health activity and user-provider relationship involved. Three contexts are distinguished in this regard: universal, target group, and individual client-provider relationship, with the nature and degree of mental health sector responsibility increasing across the levels from universal to individual client-provider therapeutic relationships.

A range of examples of specific programmes and initiatives from Ireland and elsewhere show how the mental health sector has addressed digital mental health inclusion in the various ways at each level. The examples also include initiatives implemented by the telecommunications sector to support access to and affordable usage of health services, either jointly with the health sector or within the scope of its universal service obligations.

The Chapter also recaps on the many opportunities to leverage the positive potential of digital mental health to better reach and support disadvantaged groups typically underserved by traditional mental health services. This clearly falls within the remit of the mental health sector and is also a relevant theme for attention by other sectoral organisations working with these groups.



Conclusions and recommendations



6 Conclusions and recommendations

This Chapter presents overall conclusions and recommendations for action on digital mental health inclusion in Ireland. It recaps on the importance of the topic and the sectoral mobilization required, and presents recommendations addressed to stakeholders with especially pivotal roles to play.

6.1 Importance of digital mental health inclusion

Digital mental inclusion has two core dimensions: ensuring potentially disadvantaged groups have equality of access to the same digital mental health opportunities as the general population; and purposive leveraging of digital mental health to address broader mental health inequalities across population groups. A number of converging factors have increased the importance of the issue.

Digital mental health is now a core element of the mental healthcare ecosystem

In Ireland and other countries, the COVID-19 pandemic led to accelerated deployment of digital mental health as a mainstream element of the ecosystem of mental health services and supports. Most mental health services will continue to offer remote/online consultation (by video, phone, text) as an option for clients. The pandemic also encouraged more utilization of online/digital channels for a wide range of other purposes, including enhancement and expansion of online mental health information and sign-posting; provision of psycho-education materials and programmes; delivery of CBT programmes; and hosting of peer support groups.

Important uses of digital mental health in public mental health services in Ireland include mental health information and sign-posting through the yourmentalhealth.ie website; the Counselling in Primary Care (CIPC) service for medical card holders, which expects to continue providing remote access as an option after the pandemic; and HSE-funded online CBT programmes provided by Silvercloud. Internally, HSE's video-enabled care programme provides infrastructure and supports for video consultation across its services, including primary and secondary care mental health.

The voluntary and community sector is also a central component of the system, reaching large numbers of people and serving the general public as well as a wide range of disadvantaged or otherwise vulnerable groups. Recent research has documented the nature and scale of the role the sector plays (Mental Health Reform, 2022), with estimated annual volumes of activity including: 870,000+ helpline/crisis contacts; 220,000+ counselling/psychotherapy sessions; 130,000+ reached with psychoeducation and self-help supports; and 90,000+ reached by peer support, advocacy, recovery/social inclusion and other programmes. Since the pandemic, online/digital channels have become an increasingly important mode of delivery of these services.

Groups experiencing mental health inequalities are also most affected by digital divides

As documented in Chapter 2 of this report and in other reports (e.g., NES, 2021), digital divides affect access to the information society for substantial numbers of people in Ireland. Barriers arise from lack of suitable connectivity and access devices, costs, low digital skills, and broader motivational factors. Groups experiencing digital divides because of one or more of these factors are well-documented, including less advantaged socio-economic groups, older people, and people in rural areas not reached by broadband.

The analysis in Chapter 2 also shows substantial mental health inequalities across population groups in Ireland, manifesting in higher prevalence rates for mental health difficulties and lower levels of utilization of mental health services relative to need. These patterns are especially apparent for less-advantaged socio-economic groups and for older persons, two population groupings most affected by digital divides. Intersectionality between domains is therefore an important issue for attention.

Risk of exacerbating inequalities, but also new opportunities to reach underserved groups

Developments in digital mental health pose risk of exacerbating existing mental health inequalities but also present new opportunities to reach underserved groups.

Exacerbation of inequalities

Available data is very limited on the actual nature and extent of inequalities in access to and utilization of

digital mental health in Ireland. Dedicated surveys on the topic as well as more nuanced approaches in existing national surveys would be helpful to guide policy and practice.

In the meantime, data presented in Chapter 2 from population surveys and from socio-demographic profiles of those using digital mental health services provide indications of how digital divides are already likely to be exacerbating mental health inequalities in various ways. Results from the practitioner survey presented in Chapter 3 reinforce this, showing how digital divide issues affect access to their services for a range of client groups. This is especially evident amongst mental health practitioners working in the non-profit sector. Chapter 4 looked more closely at specific barriers for a range of disadvantaged or otherwise vulnerable groupings.

New opportunities to reach underserved groups

Chapter 4 also examined the opportunities digital mental health may provide to better reach and support currently underserved groups. Logistical flexibilities of digital mental health open many new opportunities to improve access to mental health services from a range of locations, including from home and in non-traditional settings. This includes people with difficulties to physically get to mental health services (e.g., because of disabilities, caring responsibilities, distance from services, lack of transport) and people who can be reached at congregate settings frequented by otherwise hard-to-reach groups (e.g., homeless, migrants/refugees in direct provision facilities, prisoners). Digital mental health flexibilities and tools also facilitate design and tailoring of mental health services to the needs and circumstances of specific groups (e.g., different languages, ethnicities, cultures and sub-cultures). Whilst the many real opportunities presented by digital mental should be fully leveraged, it is important to avoid over-emphasis on digital approaches only; initiatives in this area should encompass optimal combinations of both digital and face-to-face service innovation.

6.2 A framework to support policy and action

Chapter 5 provides an analysis of sectoral roles and responsibilities for addressing various dimensions of digital mental health inclusion. This identified digital mental health inclusion as an important topic for focused attention within the mental health sector itself. It also indicated a need for a mental health sector led push to develop the cross-sectoral efforts required to address the inter-sectionality of digital mental health inclusion and broader digital inclusion efforts.

6.2.1 Actions within the mental health sector itself

Key stakeholders within the ‘mental health sector’ include the Department of Health, HSE mental health services, and voluntary and community sector mental health service providers. They have important roles in progressing digital mental health inclusion through development of policy and overseeing its implementation and through design and delivery of mental health services on the ground. This report provides a substantial resource of evidence to help mobilise and guide actions by these stakeholders within the mental health sector itself. The scope for action includes efforts to reduce barriers affecting access to digital mental health services as well as purposive leveraging of the positive potential of digital mental health inclusion.

The analysis in Chapter 5 identified a variety of ways the mental health sector can help reduce barriers arising from digital divide and other factors that contribute to digital mental health exclusion for vulnerable groups. These include efforts to ensure inclusive design of digital mental health services, promotion of digital mental health literacy and skills, and provision of direct practical supports such as devices and connectivity for relevant client groups and usage contexts.

The embracing of digital mental health during the pandemic, as well as the demonstrated capacity of mental health services to innovate and adapt, presents a once-in-a-generation opportunity for the mental health sector to purposively leverage the logistical and other flexibilities of digital mental health to reach and engage with previously disadvantaged and under-served groups. Digital mental health can enable new service delivery models to directly address unmet need and can also provide opportunities to ‘break the ice’ on mental health for hard-to-reach and disengaged groups. Instead of just an add-on or niche area for attention, digital mental health inclusion can be a driver of real change, better performance, and better outcomes for the mental health sector.

The overall framework for digital mental health within mental health strategy should therefore give a high

priority to digital mental health inclusion. As well as ensuring digital divides do not exacerbate existing mental health inequalities, activities developed through this lens can have much broader impacts and benefits.

6.2.2 Mental health sector led push to address the intersectionality dimensions

Although the mental health sector has a major role and responsibility for digital mental health inclusion, it is also a relevant topic for the broader social inclusion and digital inclusion sectors to address in various ways. Additionally, the expertise and resources within these sectors provide opportunities for the mental health sector to leverage in support of its mission in this domain. Relevant public policy areas include social inclusion/cohesion and promotion of the benefits of the digital society, and relevant mechanisms include provision of financial supports towards everyday living costs and specific programmes operated by Pobal and others to reach and support disadvantaged or otherwise vulnerable groups. The voluntary and community sector plays a key role in delivery of social inclusion and digital inclusion programmes and supports. Other relevant sectors include telecoms regulatory processes and telecoms providers and the tech industry.

The recently published 'Digital for Good' report from the Department of Public Expenditure NDP Delivery and Reform provides an important context for addressing the intersectional dimensions of digital mental health inclusion. A mental health sector led push to highlight the relevance and importance of the topic, and actively engage with other Departments and stakeholders to address it, would be very timely.

6.3 Recommendations

Several recommendations for action emerge from the evidence and analysis in this report. These recommendations aim to progress the digital mental health inclusion agenda by reducing barriers and leveraging positive opportunities. Key issues covered include access to and affordability of devices and connectivity, user literacy and skills, and inclusive design of services. Many of the recommendations are addressed to the 'mental health sector', which encompasses the Department of Health, HSE and other statutory agencies, and voluntary and community sector mental health organisations.

Recommendations

1. Department of Health, HSE and mental health policy implementation processes to give digital mental health inclusion high visibility and importance in current and forthcoming strategies.
2. Department of Health to engage with other Departments and agencies on measures to address access to and affordability of digital mental health as an important category of online/digital public services.
3. Mental Health Sector, within its own remit and scope of action, to develop approaches to address digital divide barriers for relevant mental health service users and usage contexts.
4. Mental Health Sector to develop a line of action within a social-inclusion/inclusion-health framework to leverage digital mental health to reach and support vulnerable groups.
5. Mental Health Sector to directly engage with mental health service users on their experience of digital mental health inclusion and involve them in developing solutions and service co-design.
6. Mental Health Sector and Adult Literacy Sector to work together to develop and implement a large-scale programme combining digital skills and mental health literacy.
7. Government to provide funding for 'bottom-up' digital mental health inclusion and innovation projects under Digital for Good or other relevant frameworks or funding mechanisms.
8. Mental Health Sector to give focused attention to accessibility of online/digital mental health for people with disabilities.

The recommendations target both reduction of barriers and leveraging the positive opportunities, and address key issues including access to and affordability of devices and connectivity, user literacy and skills, and inclusive design of services.

1. Department of Health, HSE and mental health policy implementation processes to give digital mental health inclusion high visibility and importance in current and forthcoming strategies

The evidence and analysis in this report indicate that digital mental health inclusion is an important topic for attention at strategic levels of policy and action. Department of Health, HSE and mental health policy implementation processes should give it high visibility and importance in current and forthcoming strategy on digital health, digital mental health and mental health more generally. Some key immediate contexts for this include the forthcoming Digital Healthcare Strategic Framework 2023-2030 and the Digital Mental Health Strategy under development in the context of implementation of Sharing the Vision mental health policy.

2. Department of Health to engage with other Departments and agencies on measures to address access to and affordability of digital mental health as an important category of online/digital public services

Digital inclusion is now recognized as an increasingly important social determinant of health. This needs highlighting for attention under programmes such as Digital for Good, with particular attention on measures targeted to address access and affordability for low-income groups. The Department of Health could take the lead on this and engage with other relevant Departments and agencies. The report presents examples of publicly funded approaches from other jurisdictions showing what can be done in this area.

One measure is public financial support towards the costs of broadband connectivity and devices for eligible persons or households. An example is the 'Affordable Connectivity Program' in the United States which provides discounts towards monthly internet service costs as well as a one-time discount for purchase of a laptop, desktop computer or tablet.

Another measure is to 'zero-rate' connectivity charges for utilization of designated websites or services. During the early phase of the pandemic in Ireland, ComReg announced an initiative with telecoms operators to zero-rate customer telecoms costs for usage of healthcare and educational resource websites identified by the Government. The measure also indicated customers and people without fixed broadband and dependent on mobile access would have an opportunity to avail of affordable unlimited mobile data access/package from their service provider. Currently, a number of countries have zero-rating approaches where costs are charged to the health system, including the 'Sponsored Data' programme in New Zealand and the Veterans Health Administration's 'Mobile Connectivity Support for Telehealth' programme in the United States.

Another potentially relevant approach is the long-established 'rural healthcare programme' in the United States. This includes measures such as the 'Healthcare Connect Fund' providing substantial discounts for connectivity costs for eligible rural healthcare providers.

3. Mental Health Sector, within its own remit and scope of action, to develop approaches to address digital divide barriers for relevant mental health service users and usage contexts

As well as the broader inter-sectoral approaches discussed under Recommendation 2, the analysis indicates the mental health sector should also consider, within its own remit, development of approaches to address digital divide barriers arising for relevant mental health service users and usage contexts. This might be especially relevant to enable access to digital mental health services, where indicated, for service users having a direct 'patient' or 'client' relationship with mental health services, for example, for a once-off programme of therapy sessions and/or for longer term and more episodic relationships.

The report identifies a number of local initiatives in this area by public and non-profit mental health services in England. Some examples have also been emerging in Ireland, including a currently fairly small-scale initiative within the HSE that makes SIM-enabled tablets available for frontline services to loan to clients to enable remote access to indicated clinical care. Internationally, the largest initiative in this area is probably the Veterans Health Administration 'Internet-Connected Devices' programme in the United

States which provides an internet-connected device to relevant clients so they can utilize telehealth services. This programme commenced in 2016 and is extensively utilized for access to telemental health services. Evidence indicates positive impacts through increased mental health care access, continuity and efficiency.

Given the emerging evidence of the benefits accruing for both mental health service users and providers, HSE should consider scaling up provision of devices and connectivity for relevant clients. It should also engage with voluntary and community sector mental health organisations on how they can be supported in this area, for example, through drawdown from HSE stocks and/or through funding streams to enable them to have their own stocks. In addition to devices and connectivity, mental health service users may require technical support to get set up and learn how to use the intended digital mental health service(s). The report presents some existing Irish examples of mental health services providing these forms of tech support themselves. Another approach is to build in this tech support as part of an IT supplier's contract, such as in the arrangements between HSE and its video consultation platform providers.

4. Mental Health Sector to develop a line of action within a social-inclusion/inclusion-health framework to leverage digital mental health to reach and support vulnerable groups

As well as the importance of reducing barriers arising from digital divide factors, digital mental health inclusion also opens many possibilities to leverage its positive potential to provide effective solutions for under-served and hard-to-reach groups. Voluntary and community sector organisations working with a range of vulnerable groups identified a wide variety of ways the logistical and other features of digital mental health can contribute to addressing unmet mental health needs. More generally, a number of recommendations in *Sharing the Vision* focus on enhancing mental health services for vulnerable groups, and digital mental health initiatives offer considerable opportunities to support their achievement.

HSE can make a major contribution in this area through its in-house inclusion health and social inclusion frameworks as well as through its funding mechanisms for the voluntary and community sector. Similar to Recommendation 3 above on reducing barriers, scaling up provision of devices and connectivity for relevant clients would be very helpful in supporting service innovation in this area.

Whilst digital mental health opens major opportunities for innovation in this field and can help fast-track provision of services that might otherwise be very slow to develop and implement, efforts to enhance face-to-face access to services should also be kept to the fore. Multi-channel or hybrid models combining digital and face-to-face in flexible ways can provide choice and ensure face-to-face options are not eroded or sidelined because of an over-emphasis on online/digital approaches.

5. Mental Health Sector to directly engage with mental health service users on their experience of digital mental health inclusion and involve them in developing solutions and service co-design

The current study provides compelling evidence on the importance of the digital mental health inclusion issue from a variety of sources and perspectives. While this study involved some engagement with mental health service users on their experiences in this area, it did not have scope for substantial direct engagement across a range of user groups or situations. More generally, the available literature and evidence is very limited in this regard.

The mental health sector should develop a programme of activity in this area, utilizing existing user engagement mechanisms and/or new channels of consultation as required. The programme would directly engage in various ways with mental health service users on their experience of digital mental health inclusion barriers and opportunities and involve them in developing solutions. This could include both larger scale representative surveys and more in-depth consultations with particular user groups, as well as establishment of mechanisms for user involvement in digital mental health service co-design. HSE Mental Health Engagement and Recovery might be well placed to take the initial lead on this and develop the necessary collaborations with user organisations, other HSE functions and the voluntary and community sector to progress the programme.

6. Mental Health Sector and Adult Literacy Sector to work together to develop and implement a large-scale programme combining digital skills and mental health literacy

From the user perspective, likelihood of availing of digital mental health opportunities requires not just access to devices and connectivity but also awareness of what's on offer and the motivation and skills to find and use relevant online/digital services. Digital literacy and mental health literacy are both relevant here, and significant opportunities arise to address these together in a coordinated manner. Actions in this area fall within remits of both the mental health sector and the adult education sector.

The mental health sector has an important role to play in population mental health promotion. One core line of action is through development and funding of psycho-educational programmes, either directly provided by HSE or supported through funding voluntary and community sector organisations to address this area. These approaches can help increase general mental health literacy as well as digital mental health literacy. However, for reasons of efficiency and scale, they increasingly rely on online delivery channels and so are unlikely to effectively reach those affected by digital divide barriers. More generally, motivational factors may limit the participation of many disadvantaged or otherwise vulnerable groups even if they have the possibility to connect.

Through the National Adult Literacy Agency (NALA), the adult literacy sector has been expanding its remit beyond the traditional focus on reading and arithmetic to encompass new themes emerging with societal change and trends. This includes attention to digital literacy and also to health literacy. A joint HSE and NALA programme to develop a major digital inclusion skills development programme combining digital literacy, mental health literacy and digital mental health literacy modules might be a very effective approach in this field. The branding and configuration of modules could be tailored to different delivery contexts - digital skills programmes could include mental health literacy and digital mental health literacy as application-oriented components of courses; and mental health literacy programmes could include digital and digital mental health skills as ways for participants to put mental health literacy into action.

For hard-to-reach groups, the novelty factor of digital mental health and the possibilities to address mental health within the context of broader programmes around digital inclusion could prove effective for engaging people on mental health issues in the first instance. This initial engagement might then progress to more self-help with mental health issues (whether through traditional or digital resources and tools) and increased utilization of mental health services to address unmet needs (again, whether through traditional or digital modes of service access).

7. Government to provide funding for 'bottom-up' digital mental health inclusion and innovation projects under Digital for Good or other relevant frameworks or funding mechanisms

In addition to the recommendations mentioned above, it is important to allocate funding to encourage and support "bottom-up" initiatives focusing on digital mental health inclusion and innovation. Provision of a substantial digital mental health inclusion fund seeking calls for proposals from relevant user groups and organisations working with them would provide a framework to promote innovation and collaboration to reach underserved groups through digital mental health. An effective way to do this might be through cross-departmental funding (from Departments of Health, Communications, Community Development, and others) for a programme on this topic under Digital for Good or via other relevant funding frameworks or mechanisms. The Sláintecare funding programmes for community/integrated care pilot projects may provide a useful model in this regard.

Such a fund could be open to actions that address particular pre-specified issues as well as provide more open-ended opportunities for stakeholders to develop ideas and pitch for them. Setting overall aggregate impact targets for the programme might help provide coherence and ensure value for money. For example, such a fund could aim to reach a target number of people through provision of digital mental health interventions and/or enabling them to benefit from digital mental health supports as required. Funded projects would each establish their own targets in this regard, commensurate with their scale and ambition. To provide a more concrete illustration, a suggested approach could involve allocating a relatively modest but ambitious fund of €5 million. This fund would aim to have an overall reach of

20,000+ individual beneficiaries. The fund would support a range of initiatives and projects focused on digital mental health inclusion and innovation, targeting underserved populations and addressing the specific barriers they face.

8. Mental Health Sector to give focused attention to accessibility of online/digital mental health for people with disabilities

Disability organisations consulted for this study identified a range of accessibility barriers that can exclude people with disabilities from utilizing digital mental health services. These include basic web accessibility barriers that have still not been addressed on mental health websites as well as new issues emerging with the increased provision of remote access to interactive mental health services and supports through video consultation platforms and other channels. The report provides examples of significant issues arising for a number of disability groups, including people with vision or hearing impairments.

HSE, voluntary and community sector organisations, and private mental health service providers should all give focused attention to this issue. They should ensure familiarity with, and implement, relevant national and international standards and guidance on online/digital accessibility. This includes general web accessibility requirements as well as emerging guidance on telehealth and other relevant themes (e.g., the recent WHO/ITU guidance mentioned in the report). In line with UNCRPD requirements, equally important would be to consult and engage with Disabled Persons Organisations and users with lived experience and expertise in this domain. They are uniquely placed to provide guidance on accessibility issues in this dynamically evolving field of applications and delivery platforms.

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