



Human Matters

156. Dr Stefan Heinemann
One AI to Rule Them All?!

135. Erik Van der Eycken
Person-based e-Mental Health Care

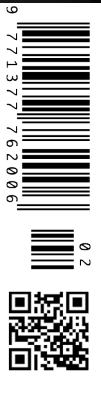
**144. A/A Prof Habeebul Rahman,
Dominic Tung Kuan San**
Staff Wellbeing – In COVID-19 and Beyond

**126. Prof Generosa do Nascimento, Dr
Alzira Duarte**
Healthcare People Management: Preparing
Today's Professionals for Tomorrow

141. Prof Geraldine McGinty
Health Inequity in Radiology and
Solutions for a More Equitable Future

**153. Dr Caterina Corbascio, Dr Gianni
Tognoni**
Mental Health Services Challenged by
COVID-19 - Analysis of a Selected Area
in Northern Italy

**161. Dr Sara Saeed Khurram, Dr Iffat
Zafar Aga**
Sehat Kahani: Addressing the Social
Phenomenon of Doctor Brides



Person-based e-Mental Health Care

A view from users' and caregivers' perspective

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E-mental health can play a role in the entire mental health care service, from data management to prevention, diagnostics, treatment, effect measurement and aftercare processes. There is a clear preference for blended care (face to face in combination with ICT-based therapy) for treatment interventions, selected carefully and adapted to the needs and the client, thus person-based. With COVID-19, experience in video consultations has been gained rapidly and the question arises how closely a teleconsultation can approach the 'human-like' circumstances of a normal therapeutic conversation.



Key Points

- E-mental health solutions can facilitate both prevention, diagnostics and treatment of relevant disorders, as well as help with outcome monitoring and relapse management.
- Mental health issues are highly individual and so should be the application of e-mental health care, going beyond fixed protocols/ICT programmes.
- The use of teleconsultations, while on the rise, imply a number of specific challenges as opposed to face-to-face care, which should be accounted for.
- E-health care solutions must be properly evaluated by all stakeholders including patients/users.
- The COVID-19 pandemic has exacerbated the problems associated with poor mental health, and this trend will continue. It is important to give mental health due attention, and an EU Year for Mental Health might be a first step in this direction.

Overall Importance of E-Mental Health

E-mental health was introduced at the beginning of this century and refers to the use of digital information and communication to support and improve mental health care.

E-health apps, websites with health information, video and teleconsultations as well as ICT for supporting processes, such as digital registration and electronic health record management, are a few examples. E-mental health can play a role in the entire health care service from data management, prevention, diagnostics, treatment, effect measurement to aftercare.

E-mental health applications offer the possibilities to reduce complaints due to mentally stressful circumstances or related to a mental disorder. This preventive care can occur in various forms, e.g. websites with psycho-education, self-tests and even treatment programmes with and without professional guidance. By offering low-threshold online help at an early stage, emerging complaints can be prevented from developing into a serious mental health problem.

Questionnaires and structured interviews are widely used to measure nature and severity of mental complaints. E-mental health could support this 'psycho-diagnostic' process. The questionnaires are then offered online via an e-health platform. After completion, the scores are automatically calculated and the care provider can often choose from different norm groups. In this way it is immediately clear how the client scores compared to this norm group.

Another category of e-mental health tools includes treatment programmes, for example, a depression-treatment programme based on computerised Cognitive Behavioural Therapy (cCBT) ([H2020-MasterMind](#)). A psycho-education application combined with a number of exercises, advice and tests could be part of it. This internet-based treatment can be offered with or without the intervention of a caregiver.

In the early introduction period of e-mental health, focus was mainly on programmes without supervision or interactive support of a professional. These are the so-called 'self-help'



programmes. However, therapy compliance turned out to be low and many clients dropped out halfway through the process of treatment. Therefore, in recent years, a clear preference for blended care (face to face in combination with ICT-based therapy) has been established. The 'online' components and face-to-face conversations do not stand alone, but are connected to each other. The online interventions are carefully selected and adapted to the treatment and the client. Separate e-health interventions can also be used to support regular treatment, such as a video explaining a certain treatment method or disorder, a mindfulness exercise, or a digital diary form.

E-mental health can also play an important role in the **implementation of Routine Outcome Monitoring (ROM)** to measure the complaint level and thus monitor the effect of the treatment. By measuring and comparing the complaint

level at different moments, the treatment result can be made transparent. On the basis of interim results, a care provider can decide to adjust the treatment.

After the treatment, client accounts often remain accessible and continue to provide access to psycho-education, exercise material, or other diary functions that were used. Many treatment programmes even end with a module specifically aimed at relapse prevention. The client can consult various tips to maintain a healthy and resilient life after the treatment.

Psychological Complaints Are Often Complex

The extent and benefits of e-mental health depend on the specific situation of the client. Every client is different and the result of applying e-mental health will vary to a greater or lesser extent and in a different way for the recovery. To be able to use e-(mental) health, it is, of course, necessary that

the client has access to the internet. Unfortunately, this is not the only necessity. A minimal degree of self-sustainability and digital skills is required to experience a significant level of comfort by the client to achieve benefits from e-mental health care. Some groups of clients such as elderly, clients with a (mild) intellectual disability, severe mental disorders, low-literate people, non-native speakers require extra attention for the effective use of e-mental health.

Taking these aspects into account, one could argue that there is little difference between e-mental and e-physical health care.

However, within specialised mental health care, psychological complaints are often too complex for a fixed protocol/ICT programme. A face-to-face contact is preferred for process-related matters, such as the introduction of a medicine or treatment, the discussion of thoughts, feelings and other behaviours resulting from a mental disorder.

Without real face-to-face contact, non-verbal communication (such as posture, motor skills, facial expressions) is lacking.

On the other hand, for some clients, a digital wall with teleconsultation has lowered the barrier to talk about certain topics that were not discussed in normal consultation, e.g. personal sexuality, fantasy thoughts and their effect on mental health.

In most cases, outpatient care was provided with the person at home, often revealing privacy concerns due to not being home alone which made the person feel uncomfortable to speak openly. In a similar context, compliance with data security and patient safety guidelines needs enough attention to put the client at ease to participate in a therapeutic teleconversation.

On a more subtle level, but somehow important for a therapy, silence during a teleconsultation was perceived differently than during a personal therapeutic conversation. In a 'normal' therapy session, a moment of silence is a time the patient is allowed to 'simply exist' without speaking in the presence of the therapist. The moments of silence during a teleconsultation usually last longer with the client often asking if the connection is lost or something else has happened. Both patients and caregivers have had this experience.

By offering low-threshold online help at an early stage, emerging complaints can be prevented from developing into a serious mental health problem

This can cause the therapist to miss or misinterpret important information. The reverse can also be the case: face-to-face contact can mislead the therapist.

From that point of view, there are some differences between e-mental and e-physical health care. Human(-like) interactions and communication between caregiver (e-applications) and client have a more comprehensive role in the treatment of mental health problems. In this sense, it is clear that with e-mental health care best results can be obtained for persons with a risk of developing mental illness, experiencing mild to moderate symptoms of mental illness. There is almost no evidence of using e-mental health in people with complex/severe mental illness or elevated risk of self-harm or suicide to improve their health condition.

Video Consultation for Mental Health Care

Because of COVID-19, experience in video/teleconsultations and e-mental health applications has rapidly built up. In a few months' time, many persons found their way to telehealth care services. A few specific aspects, positive and negative, related to video consultations were identified in the real world, both from clients' as well as professionals' perspective (Desmet 2020).

(Increased) sessions of teleconsultation led to a higher degree of fatigue for patients and professionals. This feeling of increased fatigue somehow dampens the dynamism of the consultation. In a longer term, this effect should not be underestimated.

But the most striking difference between a video session and a personal one is the abovementioned dampening effect in combination with the absence or physical presence of the therapist. A possible explanation for this can be found in the nature of a learning process through an interaction between two people. The learning process, to a certain extent, the therapeutic process cannot be exclusively attributed to information transfer. In itself there is almost no difference in information transfer between a video and a physical conversation. But the non-verbal communication, the facial expressions, etc. are part of speaking to each other. The conversation between people is in fact a physical process in which there is a kind of subconscious resonance between the conversation partners. By this, we get into the deeper state of mind and subjective physical condition of the other person. This process happens at an extremely high speed, reflectively and unconsciously.

The question therefore arises whether we can realise this phenomenon of interaction during teleconsultation.

380,000 E-Health Apps; 20,000 on Mental Health

Nowadays, there are approximately 380,000 health apps available through Apple and Android operating systems worldwide; around 20,000 of them address mental health. The type of application varies from interactive, passive, serious games, wearables to virtual and augmented reality among others (Crombez 2020).



Again, COVID-19 has created momentum for the full development in this domain of e-mental health. At the same time, there is a need for high-quality tools that should make a difference in practice as for high-quality evaluation of these tools, taking that practice into account. These developments should not be based on a cookbook method, but have to be tailor-made so that 'informed decision-making' by healthcare facility, practitioner and patient becomes possible (EFPA; DuBois 2019; Lagan et al. 2020). Two pertinent questions exist: how can we learn to distinguish quality and how can we learn to select tools?

For this, various development frameworks should be looked at, i.e. intervention mapping, behavioural intervention technology, CeHReS roadmap and person-based approach whereas all have a systematic approach in common (Bartholomew et al. 1998; Mohr et al. 2014; van Gemert-Pijnen et al. 2011; Yardley et al. 2015).

This approach has to comprise careful analysis of context and health problem, involvement of various stakeholders (patients, healthcare providers, managers, etc.), step-by-step iterative development by an interdisciplinary team, feedback and adjustment from stakeholders (not to forget the patients/users), evaluation and finally, the implementation and integration in care pathways/systems.

(E-)Mental Health Should Be Everyone's Business

Awareness of the importance of mental health has never been so high: the COVID-19 pandemic has truly put the spotlight on mental health. Rates of anxiety and depression, already increasing as a consequence of the pandemic and related measures, will only increase further as a result of the predicted economic uncertainty. Moreover, the pandemic has revealed systemic problems in the way society treats

mental health, as services have not been able to keep up with growing demand.

According to the OECD/European Commission (2018), mental ill-health affects more than one in six people across the European Union in any given year, with a total cost of over €600 billion – or more than 4% of GDP – across the 28 EU countries. Mental ill-health can affect persons at any age and in a variety of forms (e.g. depression, bipolar disorder, schizophrenia, ADHD, etc.). Mental ill-health has costs and consequences that impact individuals, families and carers, health and social systems, employers, communities and the economy. Poor mental health is consistently associated with unemployment, low income or standard of living, poor physical health, challenging life events, poor quality of life, stigma and taboo. Mental health disorders are the fastest-growing current health burden: neuropsychiatric disorders are responsible for one-third of all disabilities, for 15% of inpatient costs and for a quarter of all medication costs. Dealing with mental health problems involves a range of services such as health and social care, employment, education and housing, which are often not aware of the scale of the problem. Moreover, millions of days of work are lost each year due to mental ill-health.

That is why we should make Mental Health Everybody's Business – rather than only the business of those people directly affected by mental ill-health. And this is why GAMIAN-Europe is [campaigning](#) for an EU Year for Mental Health as an important stepping stone towards a comprehensive EU Mental Health Strategy and to make mental health everybody's business.

Conflict of Interest

None. ■

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