The digital divide: amplifying health inequalities for people with severe mental illness in the time of COVID-19

Panagiotis Spanakis, Emily Peckham, Alice Mathers, David Shiers and Simon Gilbody

Summary
During COVID-19, health provision and information resources have been increasingly provided via digital means (e.g. websites, apps) and this will become a standard practice beyond the pandemic. People with severe mental illness face profound health inequalities (e.g. a >20-year mortality gap). Digital exclusion puts this population at risk of heightened or compounded inequalities. This has been referred to as the ‘digital divide’. For any new digital means introduced in clinical practice to augment healthcare service provision, issues of accessibility, acceptability and usability should be addressed by researchers and developers early in the design phase, and prior to full implementation, to prevent digital exclusion.

Keywords
COVID-19; digital divide; digital exclusion; health inequalities; severe mental illness.

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The risk of digital exclusion among people with severe mental illness

Groups of people differ in their ability to engage with the digital world and this inequality is referred to as the digital divide. People affected by the digital divide may miss out on many of the described benefits, an experience referred to as digital exclusion. Amid the unprecedented scale of digitalisation (using digital means to provide services), the risk of exclusion becomes even greater. In the UK, 7% (3.6 million people) are non-users of the internet.1 However, limited users of the internet may also be affected by digital exclusion.

The most common factors contributing to digital exclusion are lack of skills, lack of access/means and lack of motivation.2 These factors may work synergistically. For example, lack of access to the internet might hinder people from practising and improving their skills. Finding the internet too complicated might reduce the motivation to engage.

Unfortunately, digital exclusion among people with severe mental illness (SMI) (schizophrenia, psychotic disorders, bipolar disorder and depression with psychotic features) has received little attention, despite this group experiencing some of the most profound health inequalities and having a life expectancy 20–25 years shorter than that of the general population.3 Their higher prevalence of chronic physical illnesses (such as diabetes) may further accentuate health inequalities, as the provision of self-care for such conditions becomes increasingly reliant on digital technologies. Moreover, as people with SMI are more likely to experience chronic physical illnesses, they may also need to self-isolate more often to protect themselves from COVID-19. Consequently,

Owing to restrictions imposed on social contact and mobility during the COVID-19 pandemic, the use of digital means as vehicles for individuals to receive health and social care, connect with and receive support from others, and spend leisure time has been accelerated at an unprecedented scale and speed. For example, many mental health services have shifted from face-to-face to remote delivery of healthcare and reports in the media suggest that mental health apps have been downloaded over 1 million times in the UK since the beginning of the pandemic. Registrations to use the National Health Service (NHS) app (a smartphone application portal for completing actions such as booking appointments and accessing medical records) increased by 111% from February to March 2020. Finally, leisure and creativity activities (e.g. museum visits, arts performances, physical activity classes and choir singing) have become accessible primarily via the internet.

A recent digital index population survey in the UK1 revealed the extent to which digital devices and the internet have become integral parts of many people’s lives during the pandemic restrictions: 78% of participants reported that the pandemic had increased the need for digital skills in general, 54% found video-chatting and social media use to be the key digital skills for the lockdown, 51% said that digital skills had become more necessary for their home and work life and 37% reported using more technology than before to support their mental health and well-being.

Taken together, this demonstrates the enormous potential for people to benefit from the use of digital means in the time of COVID-19. More importantly, it reveals the breadth of services, activities and resources that are not easily accessible to people who are unable to use digital technology, excluding them from important resources to support their physical and mental health needs during the pandemic.
they may disproportionately rely on the internet and deficits in digital engagement might translate into deficits in accessing essential health and social care services. Even before the pandemic restrictions, people with SMI were at increased risk of experiencing loneliness. In the present climate of disrupted social interactions, those who are digitally excluded and are therefore unable to socialise (e.g. via social media and video calls), access information or get advice and guidance online might face an even greater risk of loneliness.

People with SMI face the same common barriers to digital inclusion as the general population, as well as additional ones linked to their mental illness. Cognitive deficits and symptoms such as hallucinations may hinder use of digital devices or the process of learning how to use them. Long periods of in-patient admission can also create gaps and a loss of touch with recent technological developments. Furthermore, the design of available digital tools (e.g. apps or websites) may not consider possible cognitive deficits or health literacy levels, limiting their usability by people with SMI, especially those with coexisting intellectual disability. Thus, accessibility is important when considering how to overcome digital inclusion barriers for people with SMI.

According to an earlier study involving people with psychosis, the digital divide in the UK is narrowing. Although this is encouraging, a sizable proportion of participants (13.8%) were digitally excluded and a loss of touch with recent technological developments. Furthermore, the design of available digital tools (e.g. apps or websites) may not consider possible cognitive deficits or health literacy levels, limiting their usability by people with SMI, especially those with coexisting intellectual disability. Thus, accessibility is important when considering how to overcome digital inclusion barriers for people with SMI.

As a final point, we would urge all stakeholders involved in forums where digital services are designed and developed to consider issues of accessibility and usability of these services for people with SMI. This should be done at the outset and be an integral part of the design process.

Life and work will continue to be digitalised, with many anticipated benefits for those who are able to engage with the digital world. For others, this raises the risk of yet another form of health and social inequality. Supporting people with SMI to be digitally included is a matter of tackling inequality and improving quality of life and as such should be integral in our work with our patients and research participants.

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