Asian Journal of Psychiatry 10 (2014) 71–74

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Short Communication

Internet access is NOT restricted globally to high income countries: So why are evidenced based prevention and treatment programs for mental disorders so rare?

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ARTICLE INFO

Keywords:
Cognitive behavior therapy
Internet
Dissemination

ABSTRACT

Mental disorders are widespread and universal. They are frequently accompanied by considerable harmful consequences for the individual and come at a significant economic cost to a community. Yet while effective evidence based prevention and treatment exists, there are a number of barriers to access, implement and disseminate. Cognitive behavior therapy programs, such as those available at www.thiswayup.com.au are widely available using the Internet in high income countries, such as Australia. With the ubiquitous uptake of Internet users globally, it is suggested that low and middle income countries should consider ways to embrace and scale up these cost effective programs. An explanation of why and some suggestions as to how this can be done are presented.

1. Introduction

The developed world owns lots of expertise. Some of it is not expensive, nor is it high tech. It should be widely disseminated in low and middle income countries (LAMICs). This paper will present reasons for why and how this can be done. Both authors have a strong interest in improving mental health outcomes for individuals in LAMICs. Over a period of six months Mrs. Watts has volunteered in Kenya, working at public hospital, a school for children with disabilities, and has conducted research into parenting practices and child development. Professor Andrews has collaborated with the World Health Organization (WHO) and as part of this partnership has worked in various hospital and community settings throughout Malaysia.

2. Call for why action is needed

Mental disorders, such as the depressive and anxiety disorders are the primary cause of disability in the world (Whiteford et al., 2013). They are also the most common of the mental disorders and the considerable and harmful consequences are far reaching. For the individual and their family there are significant impacts on their day-to-day functioning, reducing capacity to work, study, develop and maintain relationships. Moreover, the individual is often subject to stigma, discrimination and victimization, with their quality of life and mortality reduced (Sarkar and Gupta, 2013; Whiteford et al., 2013). Yet, while the social and health impacts of mental disorders are often considered, the economic burden to society is frequently overlooked. Recent figures estimate that the cumulative global impact of mental disorders will amount to US$16 trillion over the next twenty years (Bloom et al., 2011). This points to the need to invest in the treatment and prevention of mental disorders and necessitates that resources are allocated appropriately. However, the world's current distribution of the health budget suggests otherwise. In high income countries, 5.1% of the health budget was allocated to the treatment and prevention of mental disorders, while many LAMICs allocated less than 2 or 1%. This discrepancy between spending is highlighted further between low and high income countries, with mental health expenditure per capita more than 200 times greater in high income countries compared with low income countries (WHO, 2011).

The negative economic impacts of mental disorders foreshadow the global epidemiology. For example, in 2010 there were almost 300 million cases of major depressive disorder (MDD) at any point in time (Ferrari et al., 2013). The prevalence rates of MDD from 53 countries showed that prevalence was lower from high income regions than prevalence from low to middle income regions,

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http://dx.doi.org/10.1016/j.ajp.2014.06.007
1876-2018/

particularly those LAMICs in conflict. More specifically, prevalence was highest in North Africa/Middle East, which included conflict countries such as Kuwait, Iraq and Lebanon, while the Asia Pacific high income region was lowest, which included countries such as Brunei, Japan and Singapore. Given their population size, Asia East and Asia-South (including China and India correspondingly) yielded the highest number of prevalence cases at over 44 million and 62 million cases respectively (Ferrari et al., 2013).

These numbers are non trivial. In response, the World Health Assembly has adopted a Comprehensive Health Action Plan 2013–2020 in May 2013 as a commitment by WHO's 194 member states to take specified actions to improve mental health. Two of the four key objectives are to "provide comprehensive, integrated and responsive mental health and social care services in community-based settings; and implement strategies for promotion and prevention in mental health (WHO, 2013)." Effective prevention and treatment strategies exist so what are the barriers that are preventing implementation and dissemination?

3. Treatment for mental disorders and barriers to implementation and dissemination

Feasible, affordable and cost-effective measures are available for preventing and treating depressive disorders for example, medication like selective serotonin reuptake inhibitors (SSRI) and psychotherapy, such as cognitive behavior treatments (CBT). Effective treatment can result in recovery and a normalized life expectancy (Gallo et al., 2013). A meta-analysis of comparisons between medication and CBT showed little difference in the short term outcomes (Cuijpers et al., 2013); however, in the longer term relapse is associated with discontinuation of medication. Consequently, CBT is the treatment of choice.

Traditionally CBT has been delivered face to face by skilled therapists. Yet, resources to meet the needs of those with mental disorders cannot be met using established mental health care systems; and this is not limited to low income countries. Limited access to evidenced based treatment and funding for resources is a global problem. For example, there were 2.15 psychologist graduates per 100,000 of the population in high income countries compared with .02 in low income countries (WHO, 2011). Moreover, the availability of trained health professionals to deliver evidenced based treatment is not only scarce but costly. Another barrier to accessing evidenced treatment may simply be that many individuals may not have the time to access mental health services offered during traditional working hours between nine and five. Lastly, stigma is widespread and remains problematic in ensuring that treatment is sought. It was in an effort to address these challenges that CBT was computerized.

4. How has Internet CBT been adopted in the Western world?

Delivering cognitive behavior therapy using a computer is effective in the treatment of anxiety and depressive disorders (Andrews et al., 2010). Andrews et al. (2010) conducted a meta-analysis of computer based psychological treatments for anxiety and depression and found a mean effect size of 0.88 (NNT 2.13). Similar results have been reported elsewhere (Andersson and Cuijpers, 2009; Cowpertwait and Clarke, 2013; Hedman et al., 2012; Richards and Richardson, 2012). Consequently the UK National Health Service now recommends two computerized programs as first line treatment, one aimed at panic and phobias, 'Fearfighter (Marks et al., 2004)' and the other aimed at depression and anxiety states, 'Beating the Blues (Marks et al., 2004).' Offering individuals access to evidenced based treatment such as CBT via a computer using the Internet offers a cost effective, highly accessible solution.

Yet, with the rising ubiquity of Smartphone use and the ability to access information in 'real time' it would seem sensible to evaluate whether CBT remain efficacious when delivered in this modality. Recent results from a pilot RCT indicate that when delivering a CBT program using a mobile application on a Smartphone clinically significant improvements in outcomes for patients with depression were seen (Watts et al., 2013). Ensuring security using a password login was highlighted as an important feature of this app and interestingly, most participants in this study accessed the mobile application while at home. This may point to the enhanced utility of accessing the program in a private, secure and comfortable environment. Importantly, this setting allows the individual to concentrate and complete the lesson in an uninterrupted, quiet space.

5. Australia a country example

In 2011 the Australian Department of Health and Aging committed $111 million AUD over four years to establish an Internet portal, MindHealthConnect, where people can source help that is evidence based. Yet, despite this investment, health professionals have been slow to engage and utilize this mode of treatment delivery and are still not up to date with how CBT programs work when delivered using a computer. The Clinical Research Unit for Anxiety and Depression (CRUfAD), University of New South Wales (UNSW) at St Vincent's Hospital, Sydney has developed and evaluated clinician prescribed courses, self-help courses, and health and wellbeing courses for school students.

5.1. Clinician prescribed courses

There are six courses that are clinician prescribed and all courses have been shown to be superior over the waitlist control (mean hedges $g = 0.92$; range 0.28–1.18; NNT ~ 2) (Robinson et al., 2010; Newby et al., 2013;Williams and Andrews, 2013; Mewton et al., 2012; Watts et al., 2013; Wims et al., 2010; Titov et al., 2011, 2008). These courses are offered on a non-for-profit basis and allow clinicians, such as primary care physicians or a mental health practitioners, to prescribe the courses for individuals with MDD, social anxiety disorder, panic disorder, generalized anxiety disorder, obsessive compulsive disorder or for people with mixed anxiety and depression (Fig. 1).

There are six lessons in each course and the content is based on CBT principles. Each lesson is akin to reading a comic book story about someone with the disorder who recovers by learning skills

Fig. 1. Meeting Jess a character with depression.