

LETTER

e-Mental health care for people living with dementia: A lesson on digital equality from COVID-19

The urgent need to mitigate the mental health consequences for vulnerable groups under pandemic conditions is clear.¹ People living with dementia (PLwD) are among the most disadvantaged. The majority of PLwD are older persons with chronic conditions with increased mortality risk, in addition to risks of infection associated with cognitive impairment, which causes difficulties in following personal hygiene instructions.^{2,3} The "stay-at-home" and visitation restrictions measures save lives, but at a cost to the mental health of PLwD and their carers: when "non-essential" activities such as psychosocial interventions are cut,⁴ negative consequences such as loneliness, depression, worsened cognition, agitation, and carer burden³ are logical outcomes, and people are left to their own devices to handle the likely long-term damage to their mental health.

This happens against a background in which otherwise healthy people manage to maintain some normality in everyday life, protected from being completely socially isolated, and being able to access non-urgent services thanks to information communication technology (ICT): virtual meetings, live chats, online learning are flourishing. In theory, the application of ICT to support "non-urgent" care is feasible; for example, initial evidence on the feasibility of videoconferencing for diagnostic interviewing in dementia can be dated back to 2007.⁵ Development in e-mental health for dementia has not seen much progress, however, until the recent wake-up call from the dire situation of COVID-19, which forces us to rethink the possibilities of best practice. Recently, we have seen dementia service providers exploring remote services via videoconferencing methods or telephone calls.⁴ The pandemic could be the turning point for e-services in health care,⁶ catalyzing implementation of e-mental health services, which may prove to be a longer-term solution beyond the current crisis.

We are witnessing a massive surge in bottom-up, needs-driven requests for ICT-supported services. In the UK, the National Institute for Health and Care Excellence (NICE) guidelines recommend that all people with mild to moderate dementia have access to group cognitive stimulation therapy (CST),⁷ in view of its benefits in enhancing cognition and quality of life. This service, provided mainly through the National Health Service (NHS) in the UK and other providers in approximately 30 countries worldwide, has been largely disrupted during the pandemic. Service providers around the world have initiated informal

testing of CST sessions delivered through Zoom or other videoconferencing platforms. Experience from practitioners in the UK, Hong Kong, and New Zealand have suggested the feasibility of connecting PLwD virtually using ICT, without concerns over confusion or disengagement, even in people who are "technology naïve" with moderate dementia. There even appears to be additional benefits with the novelty and sense of empowerment associated with ICT.

There remain challenges with e-mental health in dementia care. Using CST as an example, adaptations and fine-tuning without losing the "active ingredient" when migrating the intervention online are needed, and the online version should be subject to the same validation and evaluation process as with any evidence-based practice development. From an implementation science point of view, broader feasibility and acceptability testing is needed, for example, to address the root causes of digital inequalities (lower mental capacity, IT literacy, affordability, access to stable networks). These barriers in implementation are not insurmountable, for example, through equipment support and capacity building. Even in low-income, low-education settings, large-scale implementation of technology-enriched dementia services such as tablet-based cognitive screening has proven feasible.⁸ We should take the opportunity to consolidate these experiences to advance dementia care using ICT.

The COVID-19 pandemic will likely be a long-lasting challenge, as will the increase in the number of PLwD worldwide. We need an evidence-based approach to deliver remote services for dementia to better prepare for future crises. Even before the pandemic, service access has been a problem, with regular face-to-face service not always readily accessible due to mobility and logistic challenges (e.g., transportation, language) and staffing shortages. A remote service could break geographic barriers, bridging people from different places and backgrounds, reducing transportation time and costs, and enabling access to those with mobility and health problems which prevent attendance to groups.

A key lesson from the COVID-19 pandemic is the "slow burn of injustice,"⁹ with avoidable inequalities such as access to ICT and the e-services it enables. Such technology has been around for decades: the "father of fiber optics," Charles Kao, was himself diagnosed with Alzheimer's disease and had been advocating for

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advancement in dementia care before dying recently.¹⁰ It would only make sense if PLwD around the world could benefit from the communication technology Kao invented, as much as the rest of the world does.

CONFLICTS OF INTEREST

The authors received no specific funding and report no conflicts of interest for this work.

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How to cite this article: Dai R, Spector A, Wong G. e-Mental health care for people living with dementia: A lesson on digital equality from COVID-19. *Alzheimer's Dement*. 2020;12:e12100. <https://doi.org/10.1002/dad2.12100>