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Expanding Access to Psychotherapy: Mapping Lessons Learned from Australia and the United Kingdom to the Canadian Context

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Key Messages

Access can be improved but improving equity will require concerted effort.

- The significant increases in access to psychotherapy that have been achieved in the UK and in Australia can be replicated in Canada.
- The inequities in access and outcomes experienced with Improving Access to Psychological Therapies in the UK and with Better Access in Australia suggest that concerted effort will be required to reduce similar inequities in Canada.

There are trade-offs between grant-based and insurance-based approaches.

- IAPT's central control, tight management to standards and targets, and robust data have achieved impressive results, but require significant workforce and administrative resources.
- Better Access' more hands-off reliance on professional self-regulation and administrative Medicare data has been able to greatly increase access but provides less quality assurance.
- Either IAPT's grant-based model or Better Access' insurance-based model would be feasible in Canada's more decentralized context, where provincial and territorial governments have both sets of policy levers as well as targeted fiscal support from the $5B federal transfer.
- Universal approaches can be combined with targeted programming to promote equitable uptake.

Reforms will need to be adapted to the unique features of the Canadian context.

- Several issues that arise from the unique features of Canada's deep but narrow Medicare model demand particular consideration: whether to provide first-dollar coverage or require co-payments; inequities caused by the absence of public insurance coverage for non-physician psychotherapy providers; potential cost-shifting from employment-based insurance; and coordinating a system of stepped care.
- While existing Canadian services are challenged by fragmentation, gaps and inequities, there are strengths to draw on in community mental health, collaborative care, employment-based insurance, and on-the-ground support for implementation.
- Seamless integration with federally-funded services (for First Nations, Inuit, veterans, military personnel, refugees and people in the criminal justice system) requires additional attention in the Canadian context.
- In Canada's decentralized and two-tier system, reforms will require a strong approach to performance management, with clear equity targets from the outset.
- Workforce engagement, capacity development and increased supply have been key drivers for reform in both the UK and Australia, and may be even more so in Canada where mental health workforce planning (and data) is relatively weak.

International lessons learned point to several system design parameters.

- Based on international lessons learned, either grant-based or insurance-based Canadian reforms should: include a range of qualified providers and evidence-based psychotherapies; allow flexibility with referral mechanisms and caps on the number of sessions; and start with mild to moderate mental health problems before broadening the scope.

Canada has an opportunity to demonstrate international leadership.

- Canada has an opportunity to be an international leader in explicitly including psychotherapy for substance use, and engaging people with lived experience in the design and delivery of psychotherapy reform (including peer support).

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Introduction

Why is this an important policy issue?

Equitable access to psychotherapy[1] is a striking gap in the broad range of services and supports that are available in Canada to foster recovery and well-being across the population. The long-standing exclusion of allied mental health professional services from provincial and territorial health insurance plans has contributed to (a) high rates of unmet need (particularly for psychotherapy) (b) greater financial barriers for the estimated 12 million Canadians without access to employment-based psychotherapy benefits, and (c) broader underfunding of mental health services (at only 5 to 7% of total public spending on health in Canada) (1-4). Facing similar challenges, other OECD countries, most notably Australia and the UK, have been able to introduce major reforms to improve access to psychotherapy.

Why is there a window of opportunity for reform?

The new $5B targeted federal transfer to improve access to mental health services presents a significant opportunity for provincial and territorial governments in Canada to implement similar reforms over the next ten years. As the terms and conditions of the bilateral FPT transfer agreements have yet to be announced, it is not yet clear how much of this new funding will go toward improving access to counselling, psychotherapies and psychological services. Nevertheless, in February 2017, Ontario announced a $73M investment (over three years) in a new Structured Psychotherapy Program, and in December 2017, Quebec announced $35M for the first phase of a new public psychotherapy program (5-6). As these new programs are launched, and as other provinces and territories consider their options, there would appear to be considerable potential for reform.

What is the purpose of this discussion paper?

The purpose of this discussion paper is to support on-going dialogue and evidence-informed decision-making at the system and service-planning levels regarding the expansion of access to psychotherapy in Canada. The paper is composed of three components. The first component summarizes lessons learned from the UK and Australia. In the second component, these lessons are mapped onto Canada's unique (and uniquely decentralized) policy and service delivery context. The concluding component sets out three illustrative examples of how international lessons learned could be adapted to the Canadian context. A wide range of implementation issues are considered, building off of the Mental Health Commission of Canada's (MHCC) 2017 discussion paper and roundtable that focused on the policy rationale for expanding access and a comparison of grant and insurance-based models (7-8)[2]. While consideration of specific population groups is beyond the scope of this paper, reference is made to stages of life and diverse populations where relevant to the broader discussion. Senior provincial and territorial officials have been consulted over the course of the paper's development.

[1] In this paper, the term psychotherapy is used to refer to counselling, various psychotherapies, and psychological services, in keeping with the approach taken by the recent programs announced by Ontario and Quebec.

[2] In keeping with Chodos' 2017 paper for the MHCC, grant-based approaches "use public money to hire additional providers of counselling, psychotherapy and psychological services within publicly funded health care and social service vehicles that already exist (or that might be developed for this purpose)," and insurance-based approaches "allow privately employed providers of counselling, psychotherapy and psychological services to bill government for their services" (7).

First component: Implementation lessons learned from international reforms

Which countries will be included and why?

Implementation lessons will be drawn from the United Kingdom (England) and Australia, for several reasons. First, both countries have recent experience implementing reforms to address similar challenges to those faced in Canada, including high rates of unmet need, lost productivity, and limited public coverage of allied mental health professional services. Second, the contrast between the implementation of the grant-based approach in the UK and the insurance-based approach in Australia is instructive for considering options in the Canadian context. Third, as parliamentary democracies with broadly universal healthcare systems, the lessons learned from implementation in the UK and Australia have a high likelihood of relevance for Canada.

Service system designs in other countries that are beyond the scope of this paper may also be of interest to policy makers and planners. For example, the United States has provided public funding for psychotherapy provided by a range of allied mental health professionals since the start of Medicaid and Medicare, and the Parity Act now requires private insurers to provide mental health and substance use services on par with physical health services (9-10). The Netherlands also has a long history of public insurance for psychotherapy services provided by Primary Care Psychologists (11).

What are the key features of the UK and Australian models?

Improving Access to Psychological Therapies (IAPT) was introduced in the UK in 2008 in response to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of depression and anxiety, coupled with a very strong business case (12). IAPT is a grants-based program with distinct staff and standards, centrally administered by National Health Services (NHS) England and offered in every district. The program is free at the point of delivery, and provided by a workforce with either IAPT-specific or IAPT-approved training. IAPT follows a stepped-care model, with the majority of services offered through lower-intensity Tier 1 interventions such as online CBT-based self-help and psychoeducation groups, and a smaller number of Tier 2 face-to-face therapies as required. Pre- and post-measures of symptoms are collected at every session, and reported monthly through NHS Digital on a district-by-district basis. Clear targets were set at the outset; these included reach (15% of adults with depression and anxiety), wait times (80% seen within 28 days) and recovery rates (50%, by which IAPT means that half of the people who complete treatment will have moved from meeting diagnostic criteria for diagnosis, to not meeting these criteria).[3] While these targets have been met on average, there is considerable variation between districts and population groups. IAPT is currently expanding to include a child and youth service, and to provide services for people with co-morbid depression and anxiety and chronic physical health problems, as well as psychotherapy for people with more severe mental disorders such as schizophrenia.

In 2006, the Australian Commonwealth government introduced the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS Initiative (Better Access) in response to concerns regarding low rates of service utilization among Australians with common mental disorders (13). Better Access is an insurance-based approach that expanded universal public insurance (through Medicare) to cover psychotherapy provided by psychologists, social workers and occupational therapists. Better Access is more a specific set of Medicare items than a distinct program per se, with providers working in private practice and regulated by their respective professional associations. Providers can choose whether to charge co-payments or to provide services free at the point of delivery by bulk-billing at the Medicare rate. Better Access is complemented by smaller amounts of federal funding for two other kinds of services: Access to Allied Psychological Services (ATAPS), which is a grant-based program targeting low-income and vulnerable populations, and various internet-based Cognitive Behavioural Therapy (iCBT) initiatives coordinated through a digital mental health gateway. The estimated treatment rate for mental disorders in Australia increased from 37% in 2006-07 to 46% in 2009-

[3] IAPT's clinical definition of recovery should not be confused with recovery as a guiding principle for system transformation, as illustrated in the MHCC's definition of recovery: "living a satisfying, hopeful and contributing life, even with on-going limitations from mental health problems and illnesses." (81, p. 34)

10, although concerns have been raised about inequities in access (these will be explored in greater detail below) (14-15). Coverage of telehealth services under Better Access has recently been expanded, to improve reach in rural areas (13).

What are the implementation lessons learned from Australia and the UK?

Lessons learned from the implementation of Australia's insurance-based Better Access program and the UK's grant-based IAPT program are considered below, grouped into the following categories: planning, funding, service provision, equity and scope, monitoring, and sustainability. Supporting evidence is drawn from various policy and academic sources, and builds on the 2016 background paper and roundtable report from the MHCC (7-8). Moreover, the interviews conducted by Mary Bartram in the context of her doctoral research with key informants in the UK, Canada and Australia on government structure, service system design and equity in access to psychotherapy have provided a valuable resource for information (and quotes) regarding implementation lessons learned (16)[4]. Feedback from experts in the UK and Australia on an earlier draft of this component has also been considered.

Planning Lessons

Service system designs were closely aligned with available policy levers in specific government contexts. While this alignment may not have been explicit in the planning phase in either Australia or the UK, it does seem that both countries naturally gravitated toward the policy levers that were most readily available to them. In Australia, the insurance-based design of Better Access was able to take advantage of the federal government's jurisdiction over Medicare. Implementation was as straightforward as expanding the Medicare Benefits Schedule to include the services of psychologists and other allied mental health professionals, with referrals and treatment plans first submitted by GPs in a gatekeeper role.

> *The Commonwealth government wanted something done and wanted something done quickly. There is the question of what levers they can pull. The levers of things like the ATAPS services were more complex, and involved taking on a whole lot of additional responsibility, you have to set up and plan and deliver some kind of a stepped care model and you have to triage and you have to run in effect 100 little different mental health care systems, one for each division. In contrast to which, what you have to do to get the funding out through Medicare is you create some Medicare Benefit Schedule entitlements and you create a process which legitimizes people to use them and away they go, the rest of it is done by the private sector. (16: Australian researcher)*

Similarly, in the UK, IAPT's grant-based approach took full advantage of a more unitary government structure in England (Scotland, Wales and Ireland have developed their own approaches). For the first two years of the program, the UK Department of Health had full control over the program, even to the point of cutting the cheques for providers. While this centralized control has loosened up somewhat over the course of implementation, the program is still very resource-intensive and centrally-directed, with IAPT accountable to UK Department of Health targets, administered by NHS England, commissioned at the district level, and implemented by dedicated IAPT storefronts. This centralized approach has been critical for the introduction of IAPT as a stand-alone program, with a purpose-built workforce, tight monitoring to standards, and clear evidence of results across a number of system indicators.

True increases in access were only brought about with increased supply of psychotherapy providers. Anything less than an increase in supply could look like increased access, but actually be a shift from one type of practice to another. On the one hand, Better Access was able to draw from a steady increase in the psychology workforce that had begun in 2001, which seems to have developed organically in response to the introduction of ATAPS that year and the anticipation of further increases in public funding. Certainly, the size of the employed psychology workforce increased rapidly after Better Access was launched, from approximately 14,000 in 2006 to 22,000 in 2008 (17)[5]. On the other hand, the largest absolute increase was in major cities where the number of employed psychologists increased from 75 to 95 per 100,000 between

[4] In accordance with Carleton University's Research Ethics Board-A clearance #105482, quotes from key informant interviews are not identified by name, but rather by primary role and country of origin.

[5] See Figure 14 on page 32 of the Health Workforce Australia report (17).

2006 and 2011, in contrast to an increase from 26 to 38 per 100,000 in remote areas (17).[6] By giving psychologists the opportunity to both bill Medicare and charge co-payments, Better Access may have unintentionally compounded long-standing incentives for psychologists to practice in urban areas. For its part, IAPT actually trained up an IAPT-specific workforce, not only because there were fewer allied mental health professionals already practicing in England, but also in keeping with IAPT's aim to maintain tight control over its fidelity to evidenced-based approaches, its distinct program identity, and its stepped care model. Five thousand therapists were trained in the first 5 years, including a mix of Psychological Wellbeing Practitioners to provide low intensity interventions and more highly trained therapists (generally recognized health professionals such as psychologists, social workers, counsellors, nurses, etc. with training in IAPT-approved therapies) to provide high intensity interventions (12).

Both plans have featured strong engagement with a broad range of providers, including GPs. IAPT has included a range of service providers from the outset, cultivated through a workforce development group, a network of primary care leads, direct cultivation of champions to promote the service to colleagues, and annual national networking forums (18-19). Further, like all NHS services, IAPT services are commissioned by Clinical Commission Groups that are chiefly led by GPs as well as other service providers (20). IAPT is supported by *We Need to Talk,* a broad coalition of provider groups and mental health charities that advocates for continued expansions in access to psychotherapy (21). In Australia, Better Access has included new Medicare items for GPs, psychiatrists and psychologists from the outset. GPs have the privileged gate-keeper position, and are able to claim reimbursement for the completion of treatment plans according to a standard template (22).

Engagement with service users and inclusion of peer support has been limited. Engagement with service users, both in program design and in service delivery through public funding for peer support, does not appear to have been a strong feature of either IAPT or Better Access. Some qualitative data was gathered from service users as part of the Better Access evaluation and as part of the evaluation of a demonstration project of IAPT services for people with severe mental illnesses (23-24). Peer support has not been integrated in a systematic way into either IAPT or Better Access, although some IAPT services do provide access to the Big White Wall, an online service that includes a strong peer support component (25). It may be that the engagement of people living with mild to moderate mental illnesses is less well developed than engagement with people with lived experience of severe mental illnesses, who have typically spearheaded the consumer-survivor movement and the drive for a recovery-oriented mental health system. Nevertheless, at a time when "patient" engagement is a mantra of health system reform, the lack of engagement with service users in Better Access and IAPT is an important lesson for Canada.

Time invested in upfront planning prevented the UK from running into some of the implementation challenges experienced in Australia. Although Australia had implemented some smaller scale reforms to improve access to psychotherapy in the early 2000s, the expansion of Medicare under Better Access was implemented very quickly. The lack of planning would appear to have contributed to some unexpected challenges, including higher-than-anticipated demand and associated costs (26), inequitable distribution of services (15), and little upfront planning for evaluation and performance monitoring (23). By contrast, IAPT was meticulously planned, starting with demonstration projects, purpose-built training, and clear targets supported by extensive data collection and public reporting. While IAPT also ran into challenges with inequities between districts and ethnic groups (see below), it has had the systems in place to support on-going quality improvement.

Funding Lessons

The mix of first-dollar and co-payments was in keeping with the rest of the health system. IAPT services are free at the point of use, in keeping with the first-dollar coverage[7] provided by NHS England. In Australia, Better Access providers have the same discretion over co-payments as other Medicare providers: they can either provide services free at the point of use

[6] See Table 22 on page 39 (17).

[7] First-dollar coverage covers the full cost of a service, without any user fees or co-payments, as is the case for services covered by both NHS England and Medicare in Canada.

by "bulk-billing"[8] at the Medicare rate, or they can charge co-payments at whatever amount they decide to set. This alignment has made it easier to integrate the new services into the existing health system in both countries, although in the case of Australia this has perpetuated inequities associated with co-payments (see below).

Both grant-based and insurance-based approaches can successfully increase access. The reach and effectiveness of IAPT has steadily increased, with just under 1 million adults receiving IAPT services in 2016/17 (or just more than the original IAPT target of 15% of the 6 million people with anxiety and depression) and IAPT-defined recovery rates of nearly 50% for those completing treatment in the same time period (12, 27). As noted above, utilization of mental health treatment services in Australia climbed steeply from 37% to 46% of people with mental disorders in the first four years of Better Access (14).

Insurance-based approaches may require more careful cost-control measures, and grant-based approaches may need ring-fenced funding at the outset. With such high demand, Better Access experienced higher than projected costs: spending increased an average of 8.5% per year between 2007 and 2011 (26). Growth in utilization rates slowed after caps on the number of sessions were lowered in 2011 from 18 to 10 sessions (28). By contrast, as a grant-based program, IAPT had to protect its funding envelope from other parts of the health system. In the first two years of the IAPT program, funding was ring-fenced and managed by the UK Department of Health; funding is now part of the block of healthcare funding managed by local commissioners (12).

The risk of cost-shifting from privately-insured to publicly-funded services needs to be considered in context. This risk was particularly evident in the Australian experience, where private insurance claims for psychological services dropped off significantly after the introduction of Better Access in 2006 despite no evident changes in insurance benefits (29-30). However, this decrease needs to be considered in context. Even though about half of Australians have individually-purchased private health insurance with some form of extended health benefits, the scope of private insurance claims for psychological services was dwarfed by the subsequent uptake of publicly-funded services through Better Access.[9] It is unclear whether similar cost-shifting occurred in the UK after the introduction of IAPT, but the number of people with private health insurance is lower to begin with (estimated to be at most 11% of the population; 31).

Service Provision Lessons

A range of providers with clear scopes of practice can be effectively deployed, with or without tight ties to registration and legislation. The workforces for both Better Access and IAPT have reached beyond psychologists, with IAPT taking the most innovative approach. IAPT's low-intensity services are provided by Psychological Wellbeing Practitioners (PWPs) who have either IAPT or IAPT-approved training and supervision (IAPT PWP training is delivered according to a set curriculum over 45 days; 32). High intensity therapists are generally (but not always) allied mental health professionals who are registered with their respective colleges or associations; however, these providers are required to take IAPT or IAPT-approved training in one or more evidence-based modalities (33). IAPT does not tie scopes of practice to regulation or registration in professional colleges per se, so long as providers meet IAPT's criteria for low and high intensity therapists. By contrast, Better Access ties scopes of practice tightly to registration with relevant professional colleges, which are in turn tied to the related laws of each Australian state or territory. Better Access pays higher rebates to clinical psychologists for more intensive psychological therapies, but also covers the services of registered psychologists, social workers and occupational therapists (34-35). iCBT is still evolving in Australia as a low-intensity approach, and as yet, a PWP-style workforce is only in the early stages of development.

While system control and continuity of care is greater with GP-referral, self-referral empowers service users and promotes equitable access. Australians require a referral and a treatment plan from their GPs in order to access Better Access (22). GP-referral strengthens continuity of care between GPs and psychological services. In an insurance-based system with few

[8] If providers forego the option of charging co-payments over and above the Medicare rate, they can bill Medicare in bulk (thus "bulk-billing") and avoid the costs of collecting payments directly from service users

[9] Between 2006-07 and 2009-10 privately-insured psychological services dropped steeply (from 417,199 to 249,023 sessions); however, this drop represented only 6.7% of the growth in Better Access services (from 668,902 to 3,169,976 sessions) (30).

other controls on service provision (and thus on costs), GP-referral likely acted as both a quality control mechanism and brake on the potential for runaway demand. Ironically, demand was higher than expected despite this brake, but it is unclear how much higher costs might have escalated if self-referral had been allowed. At the same time, the National Mental Health Commission in Australia has recommended that Better Access retain GP-referral but shift the responsibility for treatment planning to allied mental health professionals, with the requirement that these be shared back to the referring GPs (36). Either way, GP-referral may be particularly viable in Australia given its high rates of physician coverage (3.52 per 1000, above the OECD average of 3.19 per 1000) and investments in rural GP capacity (37-38). By contrast, the UK has 2.79 physicians per 1000, just a bit higher than Canada's 2.66 per 1000 (37).

IAPT has taken a more flexible approach, allowing self-referral, GP-referral, and referral from employment and other community agencies. In a grant-based system with many controls on service provision, there have been fewer concerns about cost overruns; IAPT has expanded access in step with how many programs it has been able to fund, with a focus on reducing wait-times when demand has outstripped capacity. Opening the program to self-referral has not resulted in a flood of the "worried well" (who would be screened out at any rate if they did not meet criteria for the program), and has helped IAPT to improve its reach with underrepresented Black and Minority Ethnic (BME) populations (39). As will be discussed below, more equitable referral rates have not always translated into equitable outcomes, but at least IAPT is getting people in the door. While self-referral does not foster continuity of care with GPs, it may engage people who are not well-engaged with primary care (including those in rural communities with poor GP coverage).

Effective stepped care requires seamless transitions, both within and between services (including primary healthcare). IAPT is able to provide seamless stepping up and down between its low intensity and high intensity tiers. However, as a discrete service that allows self-referral, there is no guarantee of transitions with primary healthcare and more specialized mental health services. This weakness is mitigated somewhat by referrals from GPs and community agencies, and by the fact that IAPT services are often provided in community-based clinics and delivered by the same organizations that run specialist services. Moreover, with new and expanded funding, IAPT is prioritizing integration with physical healthcare; 22 new projects are underway toward a goal of placing 3000 new therapists in primary healthcare settings (40).

Better Access is not part of a stepped care approach per se, and what does exist in Australia is fragmented. Some low intensity iCBT is provided (with some federal support) by a variety of organizations (such as MoodGYM, beyondblue and ThisWayUp), but the main focus of public funding is on high intensity therapy provided in the offices of allied mental health professionals through Better Access (with some targeted programming provided through ATAPS). While GP-referral helps connect Better Access and ATAPS to primary healthcare, transitions between tiers are further complicated in Australia by State governments having jurisdiction over hospital services and the Commonwealth government having jurisdiction over primary care. As of 2015, these challenges are being prioritized in new federally-funded Primary Health Networks, which have a remit to coordinate needs-based planning with state-funded Local Hospital Networks and to strengthen the stepped-care approach for mental health service delivery (41).

Telehealth and e-health innovations can be fully integrated into service delivery models. As noted above, Australia's focus on iCBT has yet to be fully integrated into a stepped care model, and Better Access is just beginning to prioritize telehealth access (13). IAPT has included a strong focus on low-intensity services such as psychoeducation groups and online manualized CBT from the outset, and is currently making a proactive effort to assess and integrate evidence-based digital therapies (42).

Direct implementation support plays a key role in a grant-based approach. Over and above the purpose-built training and weekly supervision, IAPT provides direct change management and technical assistance to IAPT programs. This was particularly important during the initial roll-out, as providers adjusted to new requirements and as organizations adjusted to the presence of a new program.

> *I think that it is often not realized that just announcing a policy and setting out targets and some money is not a very good way of getting things to happen. If you are rolling out something that is genuinely innovative and not just fine-tuning something that exists, we really need to put the support in place at a local level… This isn't about telling people what to do, it's about facilitating learning across different parts of the NHS and across different agencies. (16: UK policymaker)*

With a rigorous performance management system, on-going training has been key for quality improvement, and inspired clinical leadership has been needed to mitigate the risk of providers feeling over-managed or judged. The National Mental Health Development Unit (funded by NHS England) provided considerable implementation support during the early years of IAPT. As IAPT's National Clinical and Informatics Advisor, David Clark has spearheaded clinical research efforts first from the London School of Economics, and more recently through his post at Oxford. Better Access is largely a self-managed program, and has not featured much in the way of direct implementation support beyond training providers to manage the paperwork and communicating eligibility criteria to the public (43). GPs are also required to take a minimum of 6 hours of mental health training to be able to bill under Better Access (44).

Strict adherence to evidence-based approaches demonstrates strong outcomes, but requires strong management and constrains choice. IAPT is managed very tightly to ensure strict adherence to the NICE guidelines, providing only therapies deemed to have sufficient levels of evidence such as Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT). IAPT has accordingly been criticized for limiting choice, and for minimizing strong evidence regarding the role of therapeutic alliance in clinical outcomes (45). IAPT co-founders David Clark and Richard Layard (an economist and member of the House of Lords) maintain that the type of therapy is more important than therapeutic alliance, and can point to IAPT's strong clinical outcomes (measured on a session by session basis) as evidence (12). Meanwhile, Better Access relies on professional self-regulation to ensure the quality of services provided. While some guidance regarding evidence-based approaches is provided, adherence is only occasionally audited (46). While this is a low-cost and defensible approach, Better Access does not have the same level of quality assurance provided by IAPT.

The average number of sessions seems to naturally land at 5 to 6, although the range will vary considerably. Prior to 2011, the cap on Better Access sessions was 6 plus 12 for exceptional circumstances, with GP approval. Even with the potential for 18 sessions, the 2011 evaluation found that only 5 sessions were used on average (23). In response to these findings as well as to concerns about unexpectedly high costs, caps were lowered to 6, with the potential for 4 more per GP review (47). IAPT would not appear to have formal caps on the number of sessions. Nevertheless, data from 2014-15 showed that people used an average of 6.3 sessions, including both low and high intensity therapies (48). However, the average number of sessions may be skewed by the inclusion of people who choose to drop out after one or two sessions, and is not indicative of the range in either jurisdiction. Some people with moderate depression and anxiety may still seek and benefit from more than even ten sessions.

Equity and Scope Lessons

Despite being universal, both IAPT and BA have run into equity problems. The most recent study has found utilization of Better Access services to be much higher in urban than in rural areas, and much lower in areas with greater socio-economic disadvantage (15). While such disparities existed prior to 2006, they were likely compounded by the ability of allied mental health professionals to charge co-payments under the Better Access scheme. Such co-payments not only pose financial barriers for service users, they also provide disincentives for providers to practice in more disadvantaged (often rural) areas.

> *Why would you as a business person trying to make a livelihood, why would you go and earn [an average salary] in a poorer area, when you can go and earn [considerably more] treating people who are more like you and who also … have needs for care, but they have more control over their lives, are more likely to turn up for appointments, and they pay more? (16: Australian researcher)*

In response to these concerns, new funding for Better Access services was introduced in 2017 to enhance telehealth services (13). The Australian National Mental Health Commission has also recommended that Better Access should offer incentives for allied mental health professionals to practice in rural areas (36). At the same time, Better Access has reached so many people that it has been able to provide unprecedented access for rural and disadvantaged populations.

> *[Better Access] made psychological services including psychotherapy affordable to the masses. …Farmers tell me that they will sit on their tractors and nobody knows that they are participating in an e-mental health program. …[F]rom the streets of highly multicultural disadvantaged communities to outback towns, … whether it is face to*

face or whether it is web-based, I know the difference people having access to psychological services is making. (16: Australian researcher)

Ethnicity and Indigenous identity were not examined in the 2011 evaluation of Better Access. However, Aboriginal and Torres Straight Islander populations in Australia have been found to have better access than non-Indigenous Australians to community mental health services, but similar rates of utilization of psychologist or psychiatrist services (49).
In England, data has focused on inequities between districts and ethnic groups; for example, in 2012/13, white people made up 89% of IAPT users, even though they make up 86% of the population of England and Wales (according to 2011 census data; 50). IAPT reported outcomes related to socio-economic deprivation (measured by the Index of Multiple Deprivation) for the first time in 2015-16 (51). While referral rates increase as deprivation increases, treatment completion rates drop off. Further, IAPT-defined recovery rates in the most deprived decile were only 35%, compared with 55% in the least deprived decile. On the one hand, these disparities are linked to broader disparities in social determinants of health. On the other hand, people may be deprived of high-quality IAPT services as part and parcel of other forms of deprivation.

[B]roadly speaking in psychology they are two views… One of them was to say, is to say, look, if you're in a socially deprived area, then your environment is just so difficult, that psychology … can only do so much for you…. The alternative view is that in most societies if you live in a socially deprived area, you're deprived of almost everything, and that includes good mental health services. One reason why you may get less good outcomes is that the services aren't so good. (16: UK researcher)

By using its extensive data to focus on quality improvement, IAPT may be able to reduce these inequities in outcomes. Cultural competency is also integrated throughout IAPT's low and high-intensity training curricula, in keeping with NICE guidelines (32, 52-53).

Universal approaches can be combined with targeted programming to promote equitable uptake. Both Better Access and IAPT are universal approaches (i.e. provided to all, without means-testing), but have added some supplemental targeting to promote equitable uptake. In Australia, the insurance-based Better Access is complemented by the smaller ATAPS program, which targets more disadvantaged groups and areas with a grants-based approach. Starting in 2017, ATAPS is being rolled into new Primary Health Networks (PHNs) with a mandate to tailor programming to the needs of district populations.

There is this recognition that Medicare is going to give you the broad coverage, but if you want to really try to address specific levels of needs that might not be catered for well by Medicare, then you might need parallel programs that are specifically designed to try to address things. For example, the PHNs have all had to do these mental health needs assessments in their areas. And that's guiding the commissioning processes. (16: Australian researcher)

In the UK, IAPT promotes tailoring to local needs at the district level. For example, local commissioning bodies and IAPT programs are encouraged to tailor services to the needs of the local population (e.g. by offering evening hours) and to partner with local community organizations to strengthen outreach to underrepresented groups while still maintaining fidelity to the model.

Basically IAPT is devolved to Clinical Commission Groups to make sure that they are meeting the needs of their local populations. It is up to them to make sure that they meet needs related to equality and diversity. If there is anything specific and tailored going on, it would be going on at that level. (16: UK policymaker)

At the same time, the IAPT target of reaching 15% of adults with depression and anxiety works against this tailoring, as there are few incentives to do outreach to hard-to-reach groups.

Specific equity targets are needed to hold both IAPT and Better Access accountable for equitable outcomes. In addition to

targets related to geography, ethnicity and socio-economic status, program uptake has been lowest for seniors and for men in both countries (50, 54). IAPT has also been collecting data on sexual orientation from the outset, and has found that recovery rates are higher for heterosexual service users than for service users who are lesbian, gay, bisexual or uncertain about their sexual orientation (51).

A narrow scope makes it easier to demonstrate results, but also creates pressures to broaden the reach. While the evidence about the outcomes of Better Access is only based on small sub-sample, it can point to clinical improvements for its target population: people with mild to moderate depression and anxiety (23). With its more robust data set and ability to screen out, IAPT has demonstrated increased recovery rates over time for people with mild to moderate depression and anxiety disorders. Although declining the service is the main reason why people who are referred to IAPT do not continue on to treatment (51), IAPT's ability to screen out people with more complex needs has contributed to its success.

> *The reason the recovery rate increased is because [staff had been] delivering interventions and they were treating people perhaps IAPT is not designed for. For example, they had some therapists in that service who were offering treatment to asylum seekers who were suffering because they were very traumatized, complex trauma…[that] we're not expected to deal with in IAPT. And they were never going to achieve recovery as defined by IAPT. So, I moved that provision into a different part of the service. (16: UK stakeholder)*

In this way, the narrow scope of both programs has contributed to their respective successes, which have in turn created pressure to broaden their reach. Australia has renewed its focus on people with more complex needs in the 2017 Fifth National Mental Health and Suicide Prevention Plan, and in the UK, IAPT is expanding its scope to include people with more complex needs and children and youth (55, 12).

People with substance use disorders may well benefit and should not be excluded from psychotherapy services. Both IAPT and BA acknowledge high rates of concurrent depression, anxiety and substance use disorders, and the potential benefits of CBT and other psychotherapies for substance use problems. IAPT only excludes people with substance use disorders if their symptoms are too severe to benefit from talk therapy (much as people with active psychotic symptoms may be excluded), and encourages IAPT services to coordinate care with substance use services (56). Even though Better Access was launched in response to statistics that included substance use disorders, the program does emphasize depression and anxiety. However, Better Access does not exclude people with substance use disorders, even as a primary diagnosis (although this would appear to be the case for less than 6% of clients) (23). It is up to GPs to determine the potential benefit of psychotherapy as they develop individual care plans, which do acknowledge substance use as a distinct component (22).

Monitoring Lessons

A true learning system requires significant investment in data, coupled with inspirational leadership. Extensive clinical and administrative data is collected through IAPT, including at each individual session. This data is released monthly, and synthesized into annual reports. Such extensive monitoring has enabled IAPT to be a true learning system, and has guided steady improvement in quality toward the achievement of targets, which have in turn been informed by NICE. However, such a data-intensive approach clearly requires significant investment of resources. Moreover, strong clinical leadership is required for IAPT providers to embrace the learning opportunities provided by the data, and to prevent the workplace from feeling punitive.

> *You could if you're not careful find yourself as a clinician working in a service where you feel … the outcome data is like a sword of Damocles hanging over you all the time…What you need to do is create a situation where you put in charge of these services really inspirational clinical leaders who are interested in the data, not because it's meeting targets and things, but instead because it's telling them and the service something really interesting about how they can achieve what they want to achieve with patients. (16: UK researcher)*

Better Access relies primarily on administrative data from MBS claims, supplemented by a sample that was created for the 2011 evaluation. This approach is far less resource-intensive, but has left funders with far less information about both the

quality of the services provided, clinical outcomes, and socio-demographic factors.

> *I think we're getting access to care by paying more providers, but that is only the first step. … [T]he missing thing is peering inside the box of the services that you'll be paying for, if you put taxpayer's money into it. The thing we commonly don't know is what actually, what intervention the person gets. (16: Australian researcher)*

Clear targets increase accountability, but can create unintended incentives. In keeping with its data-rich approach, IAPT first set clear targets, and has since been able to clearly demonstrate that these targets have been met. While targets have been met as of 2017, they have also created incentives for IAPT administrators and providers to manage to targets, which can not only provide incentives for gaming the system but can also undermine the experience of service users while placing enormous stress on service providers.

> *[W]hen IAPT was set up, there were very, very strict targets and expectations set …, and it's tight and managed within an inch of its life. Often, what strikes me is it's set up to work in a way that really work[s] against what's best for the patient... You end up distorting good clinical practice to meet targets... (16: UK researcher)*

While Better Access does not have explicit targets, it has still been able to show a sizeable increase in treatment rates for people with mental disorders (14).

Clinical supervision plays a key role in promoting fidelity to evidence-based approaches. IAPT providers are required to have weekly supervision from IAPT supervisors. These IAPT supervisors must be experienced clinicians who have taken either IAPT supervisor training, or IAPT-approved training for supervisors of evidence-based approaches that are provided by IAPT (57). In Australia, Better Access relies on the supervision and evidence-based practice requirements that are set by the professional associations of eligible providers. On the one hand, this approach takes advantage of a better-developed allied mental health workforce. On the other hand, Better Access has less control than IAPT over fidelity to evidence-based approaches.

Sustainability Lessons

Bi-partisan support and high-profile champions have been important for securing and sustaining investment. In the UK, economist and member of the House of Lords Richard Layard and psychologist and researcher David Clark have been instrumental for making the initial case for IAPT, ensuring that IAPT delivers as promised, and sustaining political support for IAPT throughout changes in government. In Australia, politicians such as former PM John Howard (who spearheaded the launch of Better Access), former Victoria premier Jeff Kennett (who launched beyondblue) and current federal Minister of Health Greg Hunt have championed mental health, and funding for Better Access has been sustained across Liberal and Labour governments. Debates amongst clinician researchers such as Ian Hickie, Graham Meadows, and Jane Pirkis have also kept Better Access in the spotlight (58, 15, 59).

> *It is quite clear that in Australia, as I look back at the major reform moments, in particular the major injections of funds, they almost universally depended on a deep personal sponsorship from either the Prime Minister or the Minister of Health at the Commonwealth level. (16: Australian stakeholder)*

CONCLUSION OF THE FIRST COMPONENT

The first component of this two-part discussion paper has focused on lessons learned from the implementation of reforms to improve access to psychotherapy in the UK and Australia. Many of these lessons highlight the relative merits of IAPT's grant-based approach vs the insurance-based Better Access initiative. Where IAPT's central control, tight management to standards and targets, and robust data collection has contributed to impressive results, the approach is highly resource intensive and requires inspiring clinical leadership to prevent undue stress on the workforce. Better Access' reliance on professional regulation and administrative Medicare data has lower levels of quality assurance, but has nevertheless been able to show impressive gains in access with a more hands-off model. Regardless of the approach, both models have confronted challenges with inequities. The second component of this paper maps these international

lessons learned onto the Canadian context, with a view to supporting on-going dialogue and evidence-informed decision-making at the system and service-planning levels regarding how best to implement similar reforms.

Second component: Adapting international lessons to the Canadian context

The second component of this discussion paper maps the lessons learned from reforms in Australia and the UK that were identified in the first component onto the Canadian context. For example, to what extent can the command-and-control approach taken in the UK be adapted to Canada's more decentralized context? What would need to be done to adapt Australia's Medicare-with-co-payments model to Canada's first-dollar Medicare system? This mapping exercise starts with the same broad categories identified in the first component, and considers the international lessons that are particularly relevant in the Canadian context as well as the information that is needed to guide high-level planning. With new federal funding starting in 2017, provincial and territorial governments are starting to announce reforms. For example, Ontario has announced a $73M investment (over three years) in a new Structured Psychotherapy Program, and Quebec has announced $35M for the first phase of a new public psychotherapy program (5-6). British Columbia has also included services for people with mild-to-moderate mental health and substance use conditions in its 2017 guidelines for primary care networks, and Newfoundland/Labrador has included expanded access to online therapy and Dialectic Behavioural Therapy as part of its bilateral funding agreement with the federal government (60-61).

What are the salient features of the Canadian context for psychotherapy reform?

The Canadian context has four features that are particularly relevant for psychotherapy reform: a highly decentralized government structure, a deep but narrow approach to Medicare, a mix of grant and insurance-based public funding models, and direct federal funding for some populations under federal jurisdiction, such as First Nations and Inuit, refugees, military personnel and veterans. The Canadian system is reviewed in more depth in the MHCC's previous paper on options for expanding access to psychotherapy (7).

The Canadian federation is highly decentralized, nowhere more so than in the health sector. Health is under provincial and territorial jurisdiction, and transfers from the Canadian federal government amount to only 23% of provincial and territorial spending on health (62). By comparison, the Australian federal government has jurisdiction over Medicare and contributes 61% of total public spending on health (63). At the same time, provincial and territorial governments in Canada do have considerable control over their health systems, but are challenged to raise enough revenue to cover rising health costs in the context of fiscal arrangements with the federal government. Between 2001 and 2016, health spending increased from 37% to 40% of total provincial program spending (averaged across all ten provinces; 64). Canada's decentralized federal structure contributed to another key feature of its health system: deep but narrow public health insurance. After intense federal/provincial negotiations in the 1950s and 1960s, first-dollar coverage (thus "deep" coverage) of hospital and physician services (thus "narrow" coverage) was introduced. Despite many efforts from all corners of the health system over the ensuing years, this coverage has never expanded to a broader range of medically-necessary services such as pharmacare, dental care, homecare and psychotherapy. While the *1984 Canada Health Act* gives provincial and territorial governments the leeway to fund these services, it does not obligate them to do so. As a result, psychotherapy in Canada is currently provided through a two-tier system. First-dollar public financing covers a narrow range of services that are either provided by family physicians or psychiatrists in private practice, in hospitals, or in publicly-funded clinics. Private financing (either through employment-based insurance or out-of-pocket payments) covers the broader range of services that are provided by psychologists, social workers, and other mental health professionals (non-physician providers). Accordingly, the estimated twelve million, generally lower-income Canadians who do not have employment-based benefits either have to pay out-of-pocket, queue for limited public services or do without (2).

While gaps and inequities characterize access to psychotherapy under this two-tier system, provincial and territorial health systems have made varying degrees of progress in providing access to publicly-funded services through a mix of insurance-based physician and hospital services and grant-based services in community mental health centres. Significant investments have also been made in various models of collaborative primary health care that typically provide access to interdisciplinary teams, including some form of mental health service provision (65). Benefits of collaborative care include improved coordination of services, patient experience, and timely access to a broader range of services. However, collaborative care models have proven expensive and have been described as "lackluster" relative to primary care reforms in counterpart countries (66-67). What is more, in the context of broader underfunding, both collaborative care and community mental health services have been challenged to provide timely access to mental health services (68-69).

One last feature stands as an exception to the general Canadian context: federal jurisdiction over psychotherapy services for some populations. Inuit and status First Nations have access to up to 22 hours of insurance-based professional psychotherapy through the federal Non-Insured Health Benefits' mental health crisis counselling program (70). Nevertheless, there are long-standing concerns about availability and cultural safety given the remoteness of many communities and variations in the cultural knowledge of service providers. Emotional supports and cultural supports (provided by Elders) have more recently been added to the Indian Residential Schools Resolution Health Support Program, although the future of this program after the Settlement Agreement has wound down (expected by 2019) is unclear. Similarly, while mental health services for veterans and military are often criticized given the high needs of these groups, the federal government funds psychotherapy services at a level beyond what is typically available to the general population. The federal government also covers up to 10 sessions of psychotherapy (20 if deemed medically necessary) for refugees (71).

On the one hand, the basic structure of publicly-funded healthcare has contributed to significant challenges in the Canadian context. For many historical reasons, Canada's total public spending on mental health is low, with estimates ranging from 5 to 7% of total public spending on health[10] compared to 13% in the UK (3, 4), and efforts to shift resources from hospital to community-based care have proved challenging. With the exclusion of allied health professionals from provincial insurance plans, unmet need for psychotherapy is particularly high (2). Significant income-based inequities in access have been found under the two-tier system (72). It has also been difficult to achieve strong accountability for results in such a decentralized system, where no one level of government has full responsibility for all aspects of health policy. This challenge is compounded for populations covered through federal programs, where fragmentation and gaps between federal and provincial/territorial services are long-standing concerns.

On the other hand, the Canadian context has several strengths that can be brought to bear on efforts to improve access to psychotherapy. Provincial and territorial jurisdiction over health has historically encouraged innovation in mental health service delivery (73) and will continue to do so. In part due to physician-centred Medicare, collaborative care models have been a strong focus of this innovation and, to some extent, allied mental health providers have been integrated into primary care settings in different ways across the country. Other sectors such as education have also made efforts to address unmet need. Meanwhile, employment-based benefits have gone some distance toward filling gaps in insurance coverage for psychotherapy, and, more recently, a few employers such as Manulife and Starbucks have made significant increases to employee mental health benefits (74-75). Lastly, governments in Canada can draw on lessons learned from a long history of federal universal insurance coverage for specific populations.

How do the international lessons map onto the Canadian context?

Implementation considerations of particular relevance to Canada are grouped into the same categories identified in the first section of this paper: planning, funding, service provision, equity and scope, monitoring and sustainability. International lessons are recapped in italics in text boxes at the outset of each category for ease of reference, with corresponding Canadian considerations highlighted in bold immediately afterward and then discussed in more detail below.

[10] While the lower estimate (5%) includes only spending on hospitals, physicians and drugs, the higher estimate includes a range of community-based services as well as services for First Nations (3, 4).

INTERNATIONAL PLANNING LESSONS - CANADIAN CONSIDERATIONS

Service system designs were closely aligned with available policy levers in specific government contexts. Policy levers for either insurance or grant-based models are available to provincial and territorial governments.

True increases in access were only brought about with increased supply of psychotherapy providers. Data on baseline workforce capacity is needed to guide increase in supply.

Both plans have featured strong engagement with a broad range of providers, including GPs. Broad support in principle from GPs and other providers already exists, but support for specific reforms will need to be built.

Engagement with service users and inclusion of peer support has been limited. Canada has an opportunity to be a leader in service user engagement and peer support.

Time invested in upfront planning prevented the UK from running into some of the implementation challenges experienced in Australia. Evidence in hand for prevalence, unmet need, clinical effectiveness, costing, and return on investment; demonstration projects are a good next step.

Planning Considerations

Policy levers for either insurance or grant-based models are available to provincial and territorial governments. Provincial and territorial governments have already implemented grants-based approaches such as community mental health programs and centres, and have full jurisdiction over Medicare. At the same time, fiscal pressures are high across the board and some of the smaller or less populated jurisdictions may not have the capacity to utilize all available levers. However, meeting the MHCC's target of increasing mental health spending from 7% to 9% of total public health funding would only cost an estimated $3.1B per year (now lessened by $500M per year from the federal government over the next ten years; 76).

Data on baseline workforce capacity is needed to guide an increase in supply. Data on baseline workforce capacity is limited and what exists is fragmented. CIHI does compile some data on psychologists, social workers and occupational therapists, with new reports due in 2018 (77). Provinces and territories likewise have varying degrees of data on their allied mental health workforce, often gathered through provincial professional associations. There is likely to be at least some degree of underutilized capacity amongst non-physician mental health service providers that could be mobilized by expanded public funding (7). However, underutilized capacity was not sufficient to enable increases in access in the UK and Australia. Workforce capacity in Canada will need to be more closely tracked to ensure that new public funding results in a true increase in supply, rather than just a shift from employment-based insurance provision to publicly-funded service provision, or from pre-existing to new publicly-funded services.

Beyond the usual types of workforce data, information may also be needed regarding supervisory and training capacity, as well as capacity to deliver specific evidence-based therapies such as cognitive behavioural therapy, interpersonal therapy and so forth. In the UK, significant planning went into assessing workforce capacity, developing purpose-built training, and training up a workforce to address gaps. These resources could potentially be adapted to the Canadian context in collaboration with post-secondary training programs, professional associations, and training institutions. Regulatory frameworks and scopes of practice may also need to be reviewed and adjusted. Currently only Ontario, Quebec, New Brunswick and Nova Scotia have regulations that protect the title of psychotherapist or counselling therapist, but regulation initiatives are underway in several other provinces (78).

Broad support in principle from GPs and other providers already exists, but support for specific reforms will need to be built. All the relevant Canadian professional associations, including the College of Family Physicians of Canada, expressed

support for expanded access to psychotherapy through the CAMIMH's 2017 report *Mental Health Now!* (79). Innovations in collaborative care have also laid a strong foundation for inter-professional collaboration in the provision of psychotherapy services. As provincial and territorial governments move forward with reforms, continued engagement with a range of providers will be needed to move from broad support in principle to support for detailed implementation including on issues such as eligibility criteria, remuneration, and scopes of practice.

Canada has an opportunity to be a leader in service user engagement and peer support. As a form of emotional and practical support between people who share common experience, peer support can make a significant contribution to improving access to mental health services and supports (80). Peer support and broader engagement of people with lived experience and their families are increasingly prioritized in Canadian mental health policy, and recognized as evidence-based practice. Both were featured as recommendations for action in the *Mental Health Strategy for Canada* (81). A 2018 research call from Health Canada asks for peer support to be studied as part of integrated primary mental health care (82), and CIHR's Strategy for Patient Oriented Research has driven service user engagement in mental health reform much as in other parts of the health system. Neither IAPT in the UK nor Better Access in Australia have been particularly strong on these fronts. Provincial and territorial governments in Canada have an opportunity to break new ground by further integrating peer support into their efforts to expand access to psychotherapy, and by further strengthening engagement with service users and families in the design and implementation of reforms.

Evidence in hand for prevalence, unmet need, clinical effectiveness, costing, and return on investment; demonstration projects are a good next step. Many of the core ingredients for planning are well in hand: the Canadian Community Health Survey data on prevalence and unmet need; evidence on clinical effectiveness has been well-documented by NICE and Canadian organizations such as Health Quality Ontario (83-84); and various studies have been carried out on costs and return on investment (85). In a detailed study regarding the costs of expanding insurance funding for psychotherapy, Vasiliadis et. al., projected costs of $123M to provide $1,292 worth of psychological services to ninety-five thousand Canadians with unmet need related to depression, and calculated that this would yield $2 saved to society for every $1 invested (86). As in the UK, demonstration projects are a good next step, to evaluate service system designs and make the case for scaling up. Although they have not said so explicitly, the level of funding announced to date by Ontario and Quebec suggests that they are both effectively starting with demonstration projects.

INTERNATIONAL FUNDING LESSONS – **CANADIAN CONSIDERATIONS**

The mix of first-dollar coverage and co-payments was in keeping with the rest of the health system. **There are advantages and precedents for either first-dollar coverage or co-payment models.**

Both grant-based and insurance-based approaches can successfully increase access AND Insurance-based approaches may require more careful cost-control measures, and grant-based approaches may need ring-fenced funding at the outset. **Canada can draw on international lessons learned to assess the trade-offs for both approaches.**

The risk of cost-shifting from privately-insured to publicly-funded services needs to be considered in context. **The risk of cost-shifting from Canadian employment-based insurance can be analysed in advance.**

Funding Considerations

There are advantages and precedents for both first-dollar coverage and co-payment models. A first-dollar, insurance-based approach (i.e. expanding Medicare eligibility for psychologists and other allied mental health professionals) would encourage seamless integration with physician and hospital services, remove financial barriers to access, and promote the parity of psychotherapy with other health services. While there have been some expansions to public health insurance in Canada (e.g. through expanded coverage for prescription medications), these reforms have generally been targeted to particular age groups or income levels, and have included some form of co-payment, either through user fees or the tax system. Co-payments would allow for more seamless integration of publicly-funded psychotherapy with employment-based benefits and discourage cost-shifting from the private to the public sector, but may not be well received given the

equity impacts and the value Canadians place on first-dollar health coverage. Provincial and territorial reforms have thus far adopted first-dollar grants-based approaches in their efforts to improve access to psychotherapy, through community mental health services and some forms of collaborative care.

Canada can draw on international lessons learned to assess the trade-offs for insurance-based and grants-based approaches. Either approach could be adapted to the Canadian context, but there are trade-offs between the degree of control over costs and other outcomes, and the administrative resources required to implement the reform. Lessons learned in the UK suggest that grants-based approaches would provide provincial and territorial governments with a high degree of control over costs and fidelity to evidence-based approaches, but would also require significant resources for the administration of everything from training to targets to data collection. Ring-fenced funding was also needed in the first few years of IAPT, and would also be advisable in Canada given the tremendous pressures faced by provincial and territorial health budgets. Lessons learned from Australia suggest that insurance-based approaches would enable provincial and territorial governments to increase access without much investment in program administration, but would also provide less control over costs and quality. At the same time, insurance-based reforms in Canada could prepare for high demand and stronger performance monitoring through some combination of workforce increases, soft caps on the number of sessions, and more rigorous data collection from the outset.

The risk of cost-shifting from Canadian employment-based insurance can be analysed in advance. Given that approximately two thirds of people living in Canada have access to employment-based benefits (2), and given the Australian experience with drops in private insurance claims after the expansion of public insurance (29), provincial and territorial policy-makers would do well to analyse the risk of cost-shifting in advance. The interests and incentives in an employment-based system are different from those that prevail in Australia, where citizens purchase insurance directly. In Canada, the insurance industry earns income from the sale of insurance, employers pay for a benefits package as part of employee remuneration, and the costs to employers go up depending on how many claims are made by employees. With increased public funding in Canada, whether through grants-based or insurance-based reform, employers may have new incentives to scale back their mental health benefits. Mechanisms that could be considered to mitigate this risk include: only making public services available to people without employment-based benefits, including comparable co-payments and regulating the insurance sector (as in the Quebec pharmacare model). That said, the scale of private health insurance utilization for psychotherapy is small relative to unmet need (30) and targeted programs with co-payments are likely to be less popular. Policy-makers in Canada may opt to provide first-dollar universal coverage to broaden the reach of reforms and thus the base of public support.

Whatever approach is taken, Canadian policy-makers will also need to consider the impact on existing publicly-funded services. For example, a first-dollar insurance-based model could duplicate the mandate of current community mental health organizations, and lead to a diminished funding base that could undermine their viability. On the other hand, grants-based approaches could be rolled out through existing community organizations, primary care teams, hospital out-patient programs, and so forth.

INTERNATIONAL SERVICE PROVISION LESSONS – CANADIAN CONSIDERATIONS

A range of providers with clear scopes of practice can be effectively deployed, with or without tight ties to registration and legislation. Canada has access to a broad range of allied providers, supported by regulation and/or certification.

While system control and continuity of care is greater with GP-referral, self-referral empowers service users and promotes equitable access. Ideally, both GP-referral and self-referral will be allowed.

Effective stepped care requires seamless transitions, both within and between services (including primary healthcare). A strong stepped care approach, with more low than high intensity services and seamless transitions, will require strong change management AND ***Seamless integration with federally-funded services requires additional attention in the Canadian context***

Direct implementation support plays a key role in a grant-based approach. Several sources of implementation support can be considered in the Canadian context.

Strict adherence to evidence-based approaches demonstrates strong outcomes, but requires strong management and constrains choice. At a minimum, access should be expanded to the same therapies currently supported by the NICE guidelines.

The average number of sessions seems to naturally land at 5 to 6, although the range will vary considerably. A mix of caps and flexibility regarding the number of sessions is warranted.

Service Provision Considerations

Canada has access to a broad range of allied providers, supported by regulation and/or certification. Better Access expanded Medicare eligibility in Australia to regulated psychologists, social workers and occupational therapists, with clinical psychologists remunerated at a higher level. IAPT went further by training a purpose-built workforce of low intensity therapists, and by tying eligibility for higher intensity therapists and supervisors to IAPT-approved skills in evidence-based approaches rather than to professional associations. Canadian policy-makers have a range of resources to draw on to effectively and efficiently expand access to psychotherapy. Psychologists, social workers, occupational therapists and nurses are regulated in all Canadian provinces and two territories. To date Ontario, Quebec, New Brunswick and Nova Scotia have regulations that protect the title of psychotherapist or counselling therapist (78). Master's-level degrees in psychotherapy and counselling are offered in various fields such as education and theology, and certification programs are also available in the peer support, psychosocial rehabilitation and substance use fields. While additional training and legislation may be needed to assure capacity in particular therapeutic modalities, the infrastructure for a broad range of allied psychotherapy providers is in place.

Ideally, both GP-referral and self-referral will be allowed. In Canada currently, GP-referral is generally needed to access psychotherapy services through grants-based collaborative care models, through employment-based insurance, and through insured services for federal populations. Self-referral is also generally allowed for access to grants-based community mental health centres. Given this mix, both referral methods will ideally be available for any expanded public program. This flexibility will be important for equitable access given high rates of physician shortages in Canada, particularly in northern and remote regions. Self-referral may also be more appealing to groups that have low rates of service utilization, such as men and immigrant, refugee, ethno-cultural and racialized (IRER) populations (72, 87).

A strong stepped care approach, with more low than high intensity services and seamless transitions, will require strong change management. Some low intensity services are in place in different jurisdictions, including online guided self-management programs such as Bounce Back, Strongest Families, Medeo and Therapy Assistance Online. However, neither low nor high intensity services are consistently available across the country. Giving priority to low intensity services for mild problems may be challenging given the unmet need for face-to-face psychotherapy for moderate problems and the

on-going pressing need for even more specialized services for more complex or severe issues. Step-up and step-down transitions will be more seamless to the extent that services are housed in a stand-alone program such as IAPT. Moreover, expanded psychotherapy services will need to establish seamless transitions with substance use services, primary healthcare (especially those practices that already focus on collaborative mental health care), and more specialized and acute health care, in addition to services in other sectors such as education and housing. For example, many universities have developed significant mental health counselling services, and integrated youth hubs that provide free psychotherapy in the community have been emerging in different jurisdictions.

Seamless integration with federally-funded services requires additional attention in the Canadian context. The fact that select population groups have access to federally-funded psychotherapy will need to be addressed in the provision of new services. Policy-makers will need to work with First Nations, Inuit and Métis to identify how best to strengthen the continuum of culturally-safe mental wellness services, without exacerbating fragmentation between provincial, territorial and federal programs. Similarly, coordination between levels of government will be needed to make the most of expanded services for veterans, military personnel, refugees, and people in the criminal justice system. For example, careful attention to differences in remuneration and co-payments will be required to ensure equity between federal, provincial and territorial programs, and to coordinate human resource planning.

Several sources of implementation support can be considered in the Canadian context. At the pan-Canadian level, the Canadian Foundation for Healthcare Improvement has considerable expertise in on-the-ground quality improvement, the MHCC and CCSA also have expertise in moving evidence into practice, and the Canadian Agency for Drugs and Technologies in Health can also support implementation by reviewing evidence for clinical effectiveness. While the 2018 external review of pan-Canadian Health Organizations made sweeping recommendations regarding the specific mandates of these organizations, it also included a strong endorsement of the role of implementation support in driving system transformation (88). Accreditation Canada also exerts considerable influence through its standards for community and in-patient mental health services. At the provincial level, health quality councils have varying degrees of capacity to support implementation of psychotherapy reforms. Research organizations may also be able to contribute, whether CIHR through SPOR and other programs, provincial research funds, or philanthropic research initiatives.

At a minimum, access should be expanded to the same therapies currently supported by the NICE guidelines. While IAPT started with a narrower range of therapies, these have broadened over time in response to NICE guideline changes. Provincial and territorial governments in Canada should at a minimum start with this broader range of therapies. How this is implemented will depend on whether policy-makers opt for a more hands-on or hands-off approach. An IAPT-style hands-on approach would see the service system get directly involved in training and supervising service providers, rather than the Australian model that leaves it up to professional associations to regulate the skills of its members in partnership with the universities that deliver accredited professional training.

A mix of caps and flexibility regarding the number of sessions is warranted. Based on the international experience, an average of 5-6 sessions (with considerable variation in the range) can be expected. If an insurance-based approach is taken, some form of caps would be advised to prevent runaway demand as occurred in Australia. At the same time, hard caps with no flexibility would be too rigid given the range of sessions needed. In the Canadian context, collaboration between expanding publicly-funded programs and employment-based insurance will also be important, to prevent cost-shifting from the private sector and to maximize increased access across the population. Similar consideration should be given to alignment with the number of sessions offered through existing publicly-funded programs at both provincial/territorial and federal levels.

INTERNATIONAL EQUITY AND SCOPE LESSONS – CANADIAN CONSIDERATIONS

Despite being universal, both IAPT and BA have run into equity problems AND Universal approaches can be combined with targeted programming to promote equitable uptake AND Specific equity targets are needed to hold both IAPT and Better Access accountable for equitable outcomes. Whether a universal, targeted or combined approach is taken in Canada, specific equity targets should be set and monitored.

A narrow scope makes it easier to demonstrate results, but also creates pressures to broaden the reach. Best to start with a clear focus on mild to moderate depression and anxiety, and plan for future expansions.

People with substance use disorders may well benefit and should not be excluded from psychotherapy services. Canada has an opportunity to break new ground in explicitly including people with substance use problems and concurrent disorders.

Equity and Scope Considerations

Whether a universal, targeted or combined approach is taken in Canada, specific equity targets should be set and monitored. Under the existing two-tier system, there are significant financial barriers for those least able to afford to pay for psychotherapy services. Moreover, low income people often face additional barriers related to racialization, stigma, housing, precarious employment and so forth, all of which are risk factors for mental health. Provincial and territorial governments could reasonably opt to take a targeted approach, by either limiting expanded funding to particular populations such as youth or to lower income groups much as has been done with targeted pharmacare insurance. Alternatively, governments could also reasonably opt for a universal approach, with the expectation that access for low-income and other disadvantaged groups would improve in absolute terms if the funding base is sufficiently large. Combining a universal approach with some targeted funding for outreach to marginalized groups would help to reduce remaining equity gaps. This outreach could be done in partnership with community organizations that have strong ties to diverse groups and the capacity to adapt psychotherapy modalities to specific cultural and other contexts.

Regardless of the approach taken, it is imperative that specific equity targets should be set and monitored from the outset, so that adjustments can be made to ensure that disparities in access and outcomes are being addressed. In the Canadian context, a broad range of socio-demographic data are of interest, including Indigenous identity, ethnicity, race, language, income, rurality, gender, age, sexual orientation, ability, country of birth, and so forth. To take just one example, linguistic diversity is on the rise in Canada; 7.7 million Canadians report a mother tongue other than English or French in 2016, 13% more than in 2011 (89). Given the central role of communication in psychotherapy, access to talking therapies in diverse languages is of great importance, including for official language minorities.

Best to start with a clear focus on mild to moderate depression and anxiety, and plan for future expansions. A narrow, clearly defined focus on people with mild to moderate illnesses was fundamental to the ability of both IAPT and Better Access to demonstrate results. Eligibility criteria are applied through either the IAPT screening process or the GP-referral and treatment plan stage of Better Access. With its initial focus on getting people back to work, IAPT also started with adults and only expanded to children and youth in a second stage. Accordingly, regardless of whether provincial and territorial governments opt for a grants-based or insurance-based approach, lessons learned from Australia and the UK suggest that it would be wise to start with clear focus on mild to moderate depression and anxiety, and possibly, only for one age group. At the same time, policy-makers could consider communicating a medium-term intention to expand to other age groups and to people with more complex needs once results have been demonstrated, and to consider integrating psychotherapy services sooner where possible within existing budgets.

Canada has an opportunity to break new ground in explicitly including people with substance use problems and concurrent disorders. While a narrow scope will be important, policy-makers in Canada have an opportunity to break new ground by explicitly including people living with mild to moderate substance use disorders as eligible recipients of new publicly-funded psychotherapy, as well as people with concurrent disorders. This inclusion would further the efforts of provincial and territorial governments to better integrate mental health and substance use services.

A true learning system requires significant investment in data, coupled with inspirational leadership. Expanded psychotherapy services are well-positioned to contribute to a learning mental health system.

Clear targets increase accountability, but can create unintended incentives. Clear targets should be set in the context of a learning system.

Clinical supervision plays a key role in promoting fidelity to evidence-based approaches. Supervisory requirements should be built into expanded services.

Monitoring Considerations

Expanded psychotherapy services are well-positioned to contribute to a learning mental health system. A commitment to transparent performance measurement was clearly articulated in all the agreements-in-principle for the new $5B targeted federal transfer for mental health. CIHI is leading work with federal, provincial and territorial governments to establish 3 to 5 common indicators that are being tied to bilateral agreements for this new transfer (90-91). As a contribution or complement to these common indicators, data on expanded psychotherapy services could include referral rates, wait-times, service utilization, symptom reduction, recovery outcomes (such as employment status or sense of belonging), and equitable access. Such a full range of data collection would be comparable to IAPT, particularly if outcome data is collected at each session, and would require inspired clinical leadership to mitigate the risk of workplace stress amongst service providers. Ideally all the provincial and territorial governments who introduce reforms in this area would agree to collect similar data that could then be publicly-reported through CIHI. With enough political will, Canada could aspire to surpass the UK by carefully tracking a broad range of recovery, equity and return-on-investment outcomes.
If jurisdictions opt to expand public health insurance, at a minimum this would mean that administrative data on a par with existing physician billing data could be collected. Whether just administrative data or a full range of performance indicators are collected, Canada could considerably strengthen its current understanding of mild to moderate depression and anxiety and the effectiveness of psychotherapy services. This information will help to contextualize commonly-reported indicators at other levels of the system, such as hospital readmission rates (90). It will also be important to monitor changes in stigma, as declining stigma may encourage more people to seek services and drive up wait-times despite increased public funding. The stigma module from the 2012 Canadian Community Health Survey could be repeated to that end (92).

Clear targets should be set in the context of a learning system. Agreement on health targets are notoriously challenging in Canada's constitutional context. Nevertheless, in the current climate of openness to indicator frameworks and interest in learning systems, policy-makers could aspire to meet or exceed the 50% target for clinical recovery that was just achieved by IAPT, and to meet or exceed the percentage point increase in access to treatment for mental disorders attained by Australia (27, 14). In keeping with policy commitments to a recovery-orientation, targets could be set for a broader range of recovery outcomes related to meaningful employment, education, housing, community engagement, self-determination, peer support, equity and so forth (93). As with robust data collection, careful attention would need to be paid to inspired clinical leadership as an antidote to the inherent risk of gaming that comes with any target.

Supervisory requirements should be built into expanded services. Depending on the approach taken, supervision requirements could align with current regulations governing the practice of eligible provider groups, much as was done with Better Access, or could be purpose-built for particular evidence-based therapies, as was done with IAPT.

*INTERNATIONAL SUSTAINABILITY LESSONS – **CANADIAN CONSIDERATIONS***

Bi-partisan support and high-profile champions have been important for securing and sustaining investment. Champions need to be cultivated in Canada including service users and families.

Sustainability Considerations

Champions need to be cultivated in Canada, including service users and families. There is a risk of reforms getting derailed by federal/provincial/territorial dynamics, particularly as any expanded funding for psychotherapy will likely stem from the federal $5B transfer. There is no clear champion for access to psychotherapy in Canada on par with David Clark and Richard Layard in the UK. For these reasons, it will be particularly important for policy-makers to cultivate both clinical and political champions, building on existing leadership forums, mental health networks, conferences and so forth. There is also an important opportunity to support service users and families to take on this role in the Canadian context.

CONCLUSION OF THE SECOND COMPONENT

The second component of this two-part discussion paper has mapped lessons learned from Australia and the UK onto the Canadian context. Either an insurance-based or grants-based approach would be feasible in Canada's more decentralized context. Policy-makers have many trade-offs and details to consider, from building workforce capacity to reducing the risk of cost-shifting from private insurance to breaking new ground with regard to peer support, engagement of people with lived experience and the inclusion of substance use disorders. A final component of this discussion paper considers how UK and Australian models could be adapted in the Canadian context by means of three illustrative examples: a grants-based approach, an insurance-based approach, and intensive integration of psychotherapy into collaborative care.

Illustrative Examples

Canadian grant-based psychotherapy model

Grant-based models for improving access to psychotherapy in Canada that both build on and adapts lessons learned from IAPT could include the following features:

Grant distribution. Provincial and territorial governments would flow funds for new psychotherapy services to existing commissioning bodies such as health authorities, regional hospitals, primary care networks, etc.

Eligible recipients. The initial scope would be people with mild to moderate mental and substance use problems, with a commitment to broaden services in a next phase; new services would be seamlessly integrated with federally-funded psychotherapy services for First Nations and Inuit and other population groups.

Eligible therapies. At a minimum, services offered would include the range of low and high-intensity evidence-based modalities offered through IAPT; flexible caps, stepped care, and referrals – including self-referral, GP-referral and referrals from other agencies - would be part of the service system design.

Eligible providers. All provider groups with demonstrated capacity to deliver the eligible therapies would be eligible; provincial and territorial governments would work with regulated providers to assess and strengthen capacity, to assess and increase supply, and to broaden regulation to include psychotherapy and/or clinical therapy where required. Certification programs for peer support and wellness workers would also be included in some capacity.

Service delivery locations. Services would be delivered in a variety of locations, including community mental health centres, community health centres, primary care networks, hospital out-patient settings, community agencies serving diverse population groups, and also in schools, youth or seniors centres, etc.; some would be offered online or by telephone.

First dollar or co-payments? Policy-makers would assess the trade-offs between first-dollar coverage to align with other publicly-funded services (both grant and insurance-based) and reduce inequities, and co-payments to align with employment-based services and reduce the risk of cost-shifting.

Engagement. Robust engagement with service providers and service users would be undertaken at all stages of program design, implementation and evaluation.

Accountability. The strongest possible performance monitoring would need to be in place, particularly as IAPT's command-and-control model is less common in Canada's more decentralized provincial and territorial systems; equity targets would be set from the outset, and return on investment would be tracked along with clinical and broader recovery outcomes.

Canadian insurance-based psychotherapy model

Insurance-based models for improving access to psychotherapy in Canada that both build on and adapts lessons learned from Better Access could include the following features:

Funding mechanism. Provincial and territorial governments would expand their public health insurance schedules to cover psychotherapy services by eligible providers.

Eligible recipients. The initial scope would be people with mild to moderate mental and substance use problems, with a commitment to broaden services in a next phase; new services would be seamlessly integrated with federally-funded psychotherapy services for First Nations and Inuit and other population groups.

Eligible therapies. At a minimum, Medicare items would cover the same range of evidence-based modalities eligible under Better Access; a flexible 10-session cap would be in place from the outset to reduce the risk of cost overruns; both self-referral and GP-referral would be allowed (without a GP treatment plan); and more attention would be paid to the development of a stepped care model from the outset.

Eligible providers. Regulated allied mental health professionals would be eligible, including psychologists, social workers, OTs, nurses and (in Ontario, Quebec and Nova Scotia) psychotherapists or counselling therapists; provincial and territorial governments would work with regulated providers to assess and strengthen capacity, to assess and increase supply, and to broaden regulation where required. Certification programs for peer support and wellness workers would also be included in some capacity.

Service delivery locations. While providers would be working on a fee-for-service basis, services could be delivered not just in private offices but in a variety of locations, including community mental health centres, community health centres, primary care networks, hospital out-patient settings, community agencies serving diverse population groups, and also in schools, youth or seniors centres, etc.; some services could also be offered online or by telephone.

First dollar or co-payments? Policy-makers would assess the trade-offs between first-dollar coverage to align with other Medicare services (and reduce inequities), and co-payments to align with employment-based services (and reduce the risk of cost-shifting).

Engagement. Robust engagement with service providers and service users would be undertaken at all stages of program design, implementation and evaluation.

Accountability. Canadian reforms would also draw on administrative health insurance data, but could go further than Better Access by establishing a stronger evaluation framework and more robust reporting requirements; equity targets would be set from the outset.

Canadian collaborative care-based psychotherapy model

Collaborative care models encourage a holistic approach to a person's needs, encompassing both mental and physical health as well as the interaction between the two.

While both IAPT and Better Access have included strong engagement with GPs and primary care, neither model has focused on collaborative primary healthcare as the main vehicle for improving access to psychotherapy. However, collaborative-care based models may be a more viable option in the Canadian context, where provincial and territorial governments have been working to integrate allied mental health providers into primary care settings in various ways for several decades. With increased funding, collaborative care might be able to provide timely access to psychotherapy for the population as a whole.

Collaborative care-based models for improving access to psychotherapy in Canada could be implemented through either a grant-based or insurance-based approach, with the same features (accountability, eligibility, etc.) described in the respective illustrative examples. In addition, key considerations for using collaborative care as the vehicle for reform could include:

Grant-based approach. Provincial and territorial governments could flow funds to improve access to psychotherapy directly to collaborative care practices, or indirectly through health authorities or other commissioning bodies. Collaborative care practices would then either hire allied mental health professionals on salary or on contract to provide eligible psychotherapy services. Examples of this model include Family Health Teams in Ontario, and the Primary Health Networks being developed in BC.

Insurance-based approach. Provincial and territorial governments could expand insurance schedules to cover psychotherapy services provided by allied mental health professionals who are in private practice yet formally attached to a collaborative care team. This approach would be similar to the GP-referral mechanism under Better Access but would require even stronger integration with primary care.

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