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**Targeting funds for better access to quality mental health care for Canadians.
Recommendations to government from the Canadian Psychological Association (CPA)
February 2017**

What we already know...

The barriers to accessing high quality mental health services are not because we don't have services that work, but because our public health services don't fund their full range. There are two basic categories of treatment for mental health problems and disorders – medication and psychological treatments. Both have their indications and effectiveness and, depending on the type of mental disorder, one or both are first line interventions.

Canadians have access to psychiatric care because physicians' services are covered by our public health insurance plans. Canadians have much less access to psychological treatments because these are provided in the main by psychologists (and some by other non-physician providers), whose services are not covered by our public health insurance plans.

Research on the effectiveness of psychological therapies in the treatment of mental disorders is clear. Psychological treatments:¹

- are effective with a wide range of mental health disorders such as depression, anxiety, eating disorders, and substance abuse; there is also good evidence for the efficacy of cognitive behavioural therapies in reducing the negative symptoms of psychotic disorders as well as traumatic brain injury.
- are less expensive than, and at least as effective as, medication for a number of common mental health conditions;
- work better than medication for most types of anxiety;
- lead to less relapse of depression when compared to treatment with medication alone;
- lead to patients who better follow through on treatment, feel less burdened by their illness and have lower suicide rates when used with medication to treat bipolar disorder;
- help to prevent relapse when included in the services and supports for persons living with schizophrenia;
- reduce depression and anxiety in people with heart disease, which leads to lower rates of disease-related deaths when combined with medical treatment; and
- lead to savings of 20 to 30 per cent in healthcare costs.

The challenge then is how to give Canadians access to the range of interventions that have proven effectiveness for mental disorders. We understand that government wants to target funds accountably – it wants to fund interventions that have been shown to work and that demonstrate effectiveness ongoing. To do so requires that we think about what we deliver, how we measure its effectiveness and when we measure it. While it is important to consider how many people access service, how long they wait for it, and what changes if any there are in the incidence, prevalence and impact of mental disorders in the populations treatments serve, it is also critical to know if the treatments being delivered are effective in ways that have meaningful impact on the lives of individuals, families, workplaces and communities. **We don't just want to give people more access to care, we want to give them more access to care that works.**

What we deliver: We want to implement treatment that has proven effectiveness. To best do this, we should deliver programmes that rely on evidence-based treatments and train health providers in their use. This best ensures fidelity to what we know works and maximizes the likelihood of good patient outcomes. This is a programmatic approach best illustrated by what has been done in the United Kingdom through its Improving Access to Psychological Therapies (IAPT) programmeⁱⁱ; a programme that is not only evidence-based, but is systematically evaluated for effectiveness as well as access. While this approach may best deliver a consistent and evidence-based service, it is a more centralized approach to service delivery which requires substantive investment in training health providers. This approach, adapted for Canada, is explained in more detail below under Option A.

Another approach to accountability is to invest in the accessibility of treatment delivered by providers whose native training already prepares them to deliver evidence-based and effective care. This approach, detailed under option B, is less centralized than Option A as well as less costly in that it does not require substantive investment in training health providers. However, it will not afford the same consistency in service delivery as would one that relies on delivery of a defined and evidence-based programme. In other words, although providers may be delivering evidence-based treatment there will be more variability in what they deliver.

How we measure its effectiveness: As mentioned earlier, we want to give people better access to care that works. Critical questions for the measurement of progress and success are:

- **What is being measured** – whether greater access is achieved or whether service is effective? Greater access will not help Canadians, their families, workplaces or communities if the accessed service is ineffective.
- **If the effectiveness of services is being measured, what are the thresholds and indicators of success** – total or partial symptom relief or remission, return to work or other roles, better subjective well-being, decreases in absenteeism, presenteeism or disability claims, quality of life, academic success?

- **How effectively are we measuring outcomes** – to have confidence in outcomes attained we need to employ psychometrically robust measures.
- **How does measurement account for other factors that may either aid or abet psychological recovery** – social or financial circumstances, other life events, or health factors that impact the original mental health problem for which someone may have sought treatment?
- **How do we determine the operative elements of good and poor outcomes so these may be replicated** - the service itself; the way it was delivered; the skills of the provider delivering it; some other characteristic of the presenting problem, the patient or his or her environment?

When we measure effectiveness: In CPA’s view, accountability must be demonstrated at the gate – we need to fund and deploy interventions that work – and accountability must continue to be demonstrated throughout the deployment of intervention. We have ample evidence that psychological treatments work for a range of psychological problems and disorders, notably the ones most likely to affect Canadians, depression and anxiety disorders. However once implemented, we must continue to monitor their effectiveness to ensure that they continue to be effective for the changing needs of patient populations, cohorts of providers, and the context of resources in which treatment is delivered. Research shows that an effective course of evidence-based psychological treatment for anxiety or depressive disorders takes 10 to 20 sessions. However, if the type of disorder is not accurately diagnosed, if only 5 sessions are made available or if the treatment delivered doesn’t have fidelity to its model, we are not likely to see effective outcomes. The ongoing evaluation of the outcomes of intervention is critical to ensuring that we are indeed delivering the right treatment to the right patient at the right time from the right provider.

OPTION A – The Programmatic Approach

This option is programme rather than provider-based. It requires training or expertise in the delivery of a defined and evidence-based set of interventions as well as ongoing measurement of their effectiveness. A programmatic approach offers more consistency in the service each user receives and more assurance that this service is evidence-based. A programmatic approach ensures accountability in two ways:

- at the outset by designing a programme of treatment delivery that is evidenced based; it deploys treatments that we know work
- ongoing, by measuring and monitoring the effectiveness of treatment delivered. Programme development is guided by the outcomes obtained.

As the Ministry is already aware, CPA commissioned a report that developed and costed out models that Canada could deploy to make psychological care more accessible to those who need it.ⁱⁱⁱ Among the report’s recommendations is that Canada adapt the UK’s Improving Access to Psychological Therapies (IAPT) programme.

The key successes of the IAPT programme in the first three years include:^{iv}

- treating more than 1 million people with IAPT services;
- recovery rates consistently in excess of 45 per cent;
- a session-by-session outcome monitoring system, collecting data on 90 per cent of contacts with service users;
- training of a new, competent workforce of nearly 4,000 new practitioners to deliver treatments recommended by the National Institute for Health and Care Excellence (NICE); and
- economic gains in terms of employment attainment and retention, with more than 45,000 people moving off sick pay and benefits.

In the UK, psychologists are responsible for the design and evaluation of the programme, the supervision or oversight of programme delivery, and, along with other specialized mental health providers, deliver complex or high intensity care. In the UK, much front-line care (called low intensity care) is delivered by persons with undergraduate degrees in psychology with additional training in the delivery of evidence-based therapies. Canada's context of health care providers differs somewhat from those in the UK. While we have a robust cohort of psychologists (approximately 18,000 which is about four times the number of psychiatrists) we also have cohorts of counsellors and social workers, some of whom also treat mental disorders and could be deployed at least as low intensity providers within an IAPT-type model.

While an IAPT-type programme relies on a centralized approach to training health providers, as well as delivering and evaluating service, it can still be nimble. What patient populations a programme serves (e.g., children and youth, seniors), the problems it targets (e.g., depression, anxiety) or where it is housed (e.g., primary care) can vary depending on the needs and resources of a particular jurisdiction. As has been the case in the UK, a jurisdiction can start by targeting a specific population or disorder and then scale up to address other problems and populations^v. The kind of programme developed will necessarily differ depending on the populations served. For example, if services target sentinel populations like children and youth, or sentinel problems like dementia, assessment and diagnosis will be critical before offering intervention. These kinds of problems will require some depth of health provider expertise at the gate. In addition, different kinds of problems will demand different kinds of psychological interventions (e.g., short course cognitive behavioural therapy for depression, cognitive remediation for someone with dementia or a head injury, relapse prevention for some kinds of chronic or recurrent disorders). In addition, how and when the effectiveness of interventions is measured may change depending on the patient population served. For example, the impact of early and appropriate intervention for a child may be best judged years after treatment takes place and then by the negative work, school and interpersonal consequences that treatment offsets.

Situated in primary care, an IAPT-type programme in Canada can be developed and staffed in response to the patient populations a primary care practice serves. If an IAPT-type programme is trialed for a sentinel problem or population, the CPA recommends careful consideration of where to start and how to scale up. For example, while the biggest return on mental health investments may indeed be children

and youth^{vi}, the quickest gains to the workplace and economy will be made if programmes target the anxiety and depressive disorders most commonly affecting adults.

PROS of a Programmatic Approach: Consistency in the delivery and evaluation of evidence-based treatment which, because of its consistency (e.g. treatment fidelity, oversight, outcome monitoring), is likely to yield better patient outcomes.

CONS of a Programmatic Approach: It requires a more centralized approach to programme development, evaluation and provider training. Training will come with costs – not just to develop programmes but also to train providers. As programmes are scaled up to include a range of patient populations or conditions, the types of interventions will change requiring different training and possibly a different cohort of service providers.

OPTION B – The Provider Approach

This option is provider-based. As mentioned earlier, it places accountability in the training *of* providers rather than in training *for* providers. This is more akin to the model deployed in Australia through its Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) Initiative^{vii} where “psychological assessment and therapy services” are provided by “clinical psychologists and focussed psychological strategies” are “provided by appropriately qualified GPs and eligible psychologists, social workers and occupational therapists”. To the best of our knowledge, while mental health training for providers is available, it is not a requirement of service delivery as it is under the IAPT. Specific services are delivered under this programme (e.g. individual therapy, group therapy) in capped amounts (e.g. 10 individual sessions and 10 group sessions)^{viii}.

As demonstrated by the IAPT programme, one does not need to deploy very specialized providers like psychiatrists or psychologists to deliver basic or low intensity care if less specialized providers are specifically trained to deliver the targeted, evidence-based treatment. Training is critical to this model because less specialized providers aren’t necessarily or consistently licensed or trained to deliver the targeted service. For example, not all social workers are mental health clinicians or licensed in Canada. Similarly, counsellors are not licensed in all Canadian jurisdictions nor consistently trained to treat mental illness. While some occupational therapists may work in the area of mental health, to the best of our knowledge, training in psychological treatments is not a core competency of that profession. Finally, in Canada, only physicians and psychologists can diagnose the full range of mental illness and only psychologists are specifically trained in the use of psychological tests that facilitate accurate diagnosis of complex mental disorders.

In the absence of training and the absence of a defined and evidence-based programme, the effectiveness of services relies on the prior training, expertise, and accountability of providers. When it comes to increasing access to quality mental health services, the following is needed:

- **expertise at the gate to effectively assess and diagnose** presenting problems so that the right level of intervention can be offered. For example, a six-year-old who is disruptive in class might have an attention deficit disorder, a developmental delay, or an emerging oppositional defiant disorder – each of which will require different types of interventions.
- **Training and expertise to deliver evidence-based care for a range of problems and disorders.** For the purposes of public accountability, such care should be delivered by providers whose licensed scope of practice includes psychological treatments or should be delivered by those whose work is supervised or overseen by providers whose licensed scope of practice includes psychological treatments.

In a provider-based approach to enhancing accessibility to psychological treatments, CPA recommends the following parameters:

- **Target funds for psychological assessment/diagnosis and treatment delivered by psychologists or under the supervision of psychologists.** The evidence-based mental health care to which Canadians do not have sufficient access is psychological care. Of all the non-physician, specialized mental health providers in Canada, psychologists
 - are the largest group of licensed providers
 - are able to assess (sometimes uniquely able to assess) and diagnose mental conditions and disorders
 - have been regulated throughout Canada for decades under robust accreditation and licensing standards
 - have psychological assessment, diagnosis, and treatment foremost among the core competencies of their profession
- **Target funds for the delivery of psychological service in primary care;** venues easily accessible by Canadians and venues where psychologists, or the mental health providers under their supervision, can deliver direct care and/or be a mental health resource to primary health care providers like family physicians and nurse practitioners. Further, mental health issues and disorders are often attendant on physical ones. Putting psychologists in primary care enables mental health promotion, illness prevention as well as treatment.
- **If the transfers include treatment funding parameters, set these at levels that will afford a sufficient dose of treatment (i.e., an evidence-based amount of treatment).** When it comes to the effective treatment of the most common of mental disorders (e.g., anxiety and depression), 12 to 20 sessions of treatment are required. Asking a surgeon to perform a 10-hour surgery in 2 hours is not likely to yield effective results. It is our understanding from the UK experience that IAPTs that have endeavoured to cut costs by capping treatment have compromised their treatment outcomes^{ix}.
- **Funding could require that a psychologist, and any mental health provider working under the psychologist's supervision, be contracted by a provincial or territorial health care practice.** The primary care practice would receive some amount of service fee relief from the federally targeted transfer for the services the psychologist provides within the parameters defined. The

work that CPA has done on costs associated with providing Canadians with better access to psychological services^x contains some costing models that may be of guidance.

- **Allow patients to self-refer for psychological services or to obtain a recommendation from their primary care providers** as is the case in the UK's IAPT. Psychologists assess and diagnose mental disorders without medical oversight. Requiring a physician's referral places a burden on the public health system and creates unnecessary bottlenecks in accessing psychological care.
- **Ensure that all the funded psychological services sessions are evaluated and make evaluation a condition of funding.** Canada houses world renowned psychotherapy researchers. CPA can facilitate the development of an advisory group of researchers who can assist in the choice or development of outcome measures and in their analysis and reporting. Further, de-identified and aggregated data regarding access to and effectiveness of service should be collected and compiled by the Canadian Institute for Health Information (CIHI).

PROS of a Provider Approach: Employs providers, or the supervision of providers (i.e., psychologists) who, by their training and licensure, can respond to the range of mental problems and disorders people present using evidence-based care. Allows jurisdictions to target providers and services to the unique needs of their patient populations. This is a less centralized and costly approach than a programmatic one because it does not require the development and ongoing administration of training providers.

CONS of a Provider Approach: Because of its provider, rather than programmatic focus there will be less consistency in the nature of services delivered by providers and, with that, a risk of less fidelity to standardized, evidence-based care. This risk can be offset by standardized outcome evaluation of services provided.

The CPA is available to the Minister and Ministry staff at any time to further discuss our recommendations and how the government might realize its mandate to make quality mental health services accessible to Canadians.

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About the Canadian Psychological Association (CPA): CPA is the national association for the science, practice and education of psychology in Canada. With over 7,000 members and affiliates, CPA is Canada's largest national association of psychologists.

CPA's mandate is to:

- improve the health and welfare of Canadians;
- promote excellence and innovation in psychological research, education and practice;
- promote the advancement, development, dissemination and application of psychological knowledge; and

- provide high-quality services to members.

There are approximately 18,000 psychologists registered to practice in Canada. This makes psychologists the largest group of regulated, specialized mental health care providers in the country – outnumbering psychiatrists 4:1.

ⁱ http://www.cpa.ca/docs/File/Practice/TheEfficacyAndEffectivenessOfPsychologicalTreatments_web.pdf;

<http://www.cpa.ca/cpsite/UserFiles/Documents/publications/Cost-Effectiveness.pdf>

ⁱⁱ <https://www.england.nhs.uk/mentalhealth/adults/iapt/>

ⁱⁱⁱ http://www.cpa.ca/docs/File/Position/An_Imperative_for_Change.pdf

^{iv} <http://www.iapt.nhs.uk/silo/files/iapt-3-year-report.pdf>

^v <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

^{vi} Roberts, G. and Grimes, K. (2011). Return on Investment. Mental Health Promotion and Mental Illness Prevention. Canadian Policy Network (CPNET) and Canadian Institute of Health Information (CIHI)

^{vii} <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba>

^{viii} <http://www.health.gov.au/internet/main/publishing.nsf/content/health-pcd-programmes-amhpm>

^{ix} Personal communication December 2015, Dr. David Clark, developer of the UK's IAPT

^x http://www.cpa.ca/docs/File/Position/An_Imperative_for_Change.pdf