Targeting funds for better access to quality mental health care for Canadians

Recommendations to governments from
the Canadian Psychological Association (CPA)
the Association of Psychologists of Nova Scotia (APNS),
the Association of Psychology in Newfoundland and Labrador (APNL),
the Psychological Association of Prince Edward Island (PAPEI), and
the College of Psychologists of New Brunswick (CPNB)

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In December 2016, the federal Ministers of Finance and Health put a Health Accord offer on the table to the provinces and territories; an annual 3.5% increase in the Canada Health Transfer (CHT), along with 6 billion dollars for homecare over 10 years, 5 billion dollars for mental health over 10 years and $544 million over 5 years for prescription drug initiatives and health innovation. While all the provinces and territories initially rejected the offer, nine have since signed on: Prince Edward Island, New Brunswick, Newfoundland and Labrador, Nova Scotia, Saskatchewan, British Columbia and the Northwest Territories, Nunavut and the Yukon.

The Canadian Psychological Association (CPA) stated publicly[i] that the 2016 Health Accord proposed by the federal government was a watershed moment for mental health in Canada. The Accord promised to target funds to redress the very significant gaps in mental health services available to the Canadian public. Following the December 19th meeting of health and finance ministers, the CPA urged the governments to go back to the table and find a way forward for mental health care[ii].

The CPA has long been committed to this task. In 2013, the CPA commissioned a report from a group of health economists that created and costed out several models of delivering enhanced access to psychological services. The report, authored by David Peachey, Vern Hicks and Orvill Adams, provides a business case for improved access to psychological services in Canada, demonstrating positive return on investment and proposed service that yields desired outcomes[iii]. The findings from that report formed the basis of the CPA's recommendations to the federal government about how funds targeted for mental health care could best be spent[iv].

Following a meeting with the Ministry of Health in February 2017, the CPA sat down with its eastern provincial psychological association partners (Association of Psychologists of Nova Scotia, Association of Psychology in Newfoundland and Labrador, College of Psychologists of New Brunswick, Psychological Association of Prince Edward Island) to discuss how federal investments in mental health could have the greatest impact in Atlantic Canada; how could these investments best improve access to high quality mental health services. What follows is the result and recommendations of those discussions.

What we know

The need to increase access to mental health services in Canada is considerable. One in five Canadians will experience a mental health problem in a given year[v] and only a third report that they have sought and received the help they need. Canadians either pay out of pocket for psychological services or rely on the private health insurance plans provided by their employers. The coverage provided through private health insurance is almost always too low for a clinically meaningful amount of psychological service. While Canada's public sectors (e.g. healthcare systems, schools, correctional facilities) do employ psychologists, this salaried resource has diminished. Public institutions face their own budget challenges which impact health human resource and positions that remain bring very challenging conditions of work. Publicly funded mental health services, when available, are therefore often in short supply. Those who cannot afford to pay for private psychological care end up on long wait lists, get less than optimally effective help, or simply do not get help at all.

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

- 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

The challenge then is how to give Canadians access to the range of interventions that have proven effective for mental disorders. We understand that the federal government wants to target funds accountably. It wants the funds to go directly to mental health. It wants to fund interventions that have been shown to work. It wants to fund interventions 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.**

A way forward

As articulated in a letter from the CPA and the College Family Physicians of Canada (CFPC)[vii] to Minister Philpott in January 2017, integrating mental health services into primary and community care helps ensure early and effective access to mental health care, delivered more effectively and cost effectively in communities than in expensive tertiary care facilities. Countries like the United Kingdom and Australia have realized returns on investments in psychological services in communities, easily accessible by patients who need them.

The CPA and its Atlantic psychological association partners agree that the most effective and efficient means of achieving better access to psychological services is to invest in integrated collaborative care practices in primary care settings across the Atlantic provinces.

It is widely recognized that health problems, particularly those that are chronic and recurrent, are best addressed through collaborative care[viii]. Collaborative care is patient-centered, responds to the needs of the population it serves, offers evidence-based care, measures treatment outcomes that are meaningful to the patient, and holds health providers accountable for care provided and outcomes attained[ix]. It is not health providers co-locating to provide treatment to patients but health providers working collaboratively with patients and patient populations to effectively meet their health care needs.

When it comes to mental health, Canada falls far short of delivering effective care to patients in communities. While patients bring their mental health problems to primary and community care practices, our public health insurance systems do not fund the delivery of evidence-based psychological care in those practices. Primary care providers often do not have the skill, time or resource to deliver psychological care and collaborative care teams are often not sufficiently funded to hire the depth and breadth of mental health human resource they need.

Fill the gaps

To increase access to quality mental health services, the following is needed:

- **We need a system that puts the right mental health provider at the right place so that the right care reaches the right person**. The evidence-based mental health care to which Canadians do not have access under our current publicly funded system is psychological care or psychotherapies. This is because these services are delivered by psychologists and other providers like clinical social workers and counsellors whose services are not funded by our public health insurance plans. Psychologists make up the largest group of Canada's regulated and specialized mental health resource. To the best of our knowledge, it is only physicians and psychologists whose licensed scopes of practice include the diagnosis of mental illness.

- **We need more expertise at the gate to effectively assess and diagnose patients' presenting mental health problems.** Within our current publicly funded systems, access to care is impeded by requirements for physician assessment and referral when in fact mental disorders can be assessed and diagnosed by psychologists. Indeed, psychologists working fee-for-service in the community assess, diagnose and treat patients without medical referral or oversight. If psychologists were deployed in primary care, people in need could get matched to treatment quicker. **The importance of assessment and diagnosis cannot be underestimated. Were funds deployed only for intervention, matching people's needs to services would be compromised**. 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. A senior who isn't eating or socializing might be experiencing grief, depression or an emergent dementia – again, each of which will require different types of interventions and services. We need regulated mental health providers who can assess and diagnose mental and cognitive disorders to ensure that the right service reaches the right patient.

- **We need regulated mental health providers with the training and expertise to plan, deliver, and/or oversee evidence-based care for a range of problems and disorders**. 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. While countries like Australia position psychologists on the front line of service delivery through their Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative[x], the United Kingdom, through its Improving Access to Psychological Therapies (IAPT)[xi] program positions psychologists to do assessment, supervision of low intensity care, program development and evaluation and delivery of complex care. Both programs are models which effectively mobilize a range of service providers. In the IAPT model, much of the care delivered is low intensity care delivered by trained providers and only overseen by more specialized providers like psychologists.

- **We need mental health providers with the training and expertise to evaluate the quality and effectiveness of services provided**. To ensure that the care provided is effective and efficient, it must be systematically evaluated. Further treatment outcomes must be analyzed and reviewed and used to guide future clinical decision-making.

How to do it

The Canadian Psychological Association, the Association of Psychologists of Nova Scotia (APNS), the Psychological Association of Prince Edward Island (PAPEI), the College of Psychologists of New Brunswick (CPNB), and the Association of Psychology in Newfoundland and Labrador (APNL) recommend that the federal funds targeted for mental health in the eastern provinces be used to augment mental health services in collaborative primary care settings in the following ways:

- **Staff primary care settings with psychologists who assess and diagnose mental disorders, plan and evaluate treatment, oversee the delivery of low intensity mental health care, as well as deliver complex psychological care**. In addition to delivering or overseeing the delivery of care, psychologists can be a mental health resource to primary health care providers like family physicians and nurse practitioners as they manage the biopsychosocial aspects of health and illness. 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. Integrating mental health services into primary care settings brings needed service to people in venues where they already go for health care. Situating psychologists in primary care settings gives people better access to cost and clinically effective mental health care.

- **Ensure the mental health services integrated into primary care use a stepped care approach**. Stepped care approaches have two essential features. First, treatments offered are ones that are least intensive but still likely to provide positive clinical outcomes. Second, stepped care should be self-correcting. For example, a psychologist does a thorough assessment to determine diagnosis and makes a recommendation for the patient to be seen by a counsellor. Treatment is evaluated and if it appears that the patient has more complex needs or other needs, then another step of care is introduced. Other steps might include family therapy offered by a social worker, a medication review by the family physician, referral to a psychiatrist, or more intensive psychotherapy with a psychologist. It is important when staffing a stepped

care model in primary care that practices are staffed with providers whose skill sets and scopes of practice respond to the needs of the patient populations they serve.

- **When staffing primary care practices with a mental health human resource, it is critical that caseloads permit them to deliver 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. By analogy, 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[xii].

- **Funding could require that a psychologist, and any mental health provider working within the primary care practice, be contracted by their provincial or territorial health authority**. The federal funds targeted for mental health could deliver some amount of service fee relief 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 contains some costing models that may be of guidance[xiii].

- **Allow patients to self-refer for psychological services or to obtain a recommendation from their primary care providers**. Psychologists assess and diagnose mental disorders without medical oversight. As mentioned earlier, requiring a physician's referral places unnecessary burden on physician providers and creates unnecessary bottlenecks in accessing psychological care. Indeed, in the UK IAPT model, patients can self-refer for service or be referred by a health care provider[xiv].

- **Ensure that all the funded psychological service sessions are evaluated and make evaluation a condition of funding.** Psychologists can select, administer and interpret evidence-based psychometric tools to evaluate services delivered in a primary care setting. Furthermore, Canada houses world renowned psychotherapy researchers. The 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).

- **Allow provinces, territories and health care authorities to target psychological service delivery to sentinel populations as needed.** There are unique needs across provincial and territorial jurisdictions. Funds within primary care may be allocated towards sentinel populations, such as children and youth or sentinel problems, such as depression and anxiety. Programs can be trialed and evaluated, then scaled up to treat more people or scaled across to reach a broader range of problems.

A cautionary note

The work of organizations like the Mental Health Commission of Canada (MHCC), the Canadian Alliance of Mental Illness and Mental Health (CAMIMH), and Bell have done a terrific job in raising awareness about mental health and mental illness. Canadians are speaking up and speaking out about mental

health – their experiences and struggles and their needs. It is now time, some would argue past time, to answer their needs and make quality mental health care accessible to Canadians. In doing so, it is important that all levels of government and service providers take a thoughtful approach to service delivery. One of the great challenges when it comes to public discussion of mental illness is that we treat and talk about it as if it is a single issue or condition. It isn't.

The needs of a child with autism, a mom with postpartum depression, an adult with ADHD or a senior with obsessive compulsive disorder are not the same. Indeed, an unengaged teenager struggling with school may be living with depression, drug abuse, the effects of a head injury or experiencing a first episode of psychosis. Structured psychotherapies embraced by some will not answer the needs of many, especially if delivered in the absence of assessment, diagnosis and the availability of more specialized practitioners should higher intensity care be needed.

There is no more a one-stop shop solution to mental illness than there is to physical illness. It is important that any care delivered through the federally targeted program include appropriate assessment and diagnosis, stepped care models of service delivery, positions the right providers in the right proportions to address the mental health needs of the populations they serve, and evaluates and is guided by its treatment outcomes.

To make a difference, provinces need to think carefully and thoroughly about what and how to make service available. We need to mobilize a range of resources and a range of service providers to work with patients to deliver the care they need and the care that works. We need to fund psychologists along with psychiatrists to assess and diagnose mental illness – this will get patients to the right care faster. We need to fund evidence-based psychotherapies, some of them structured, by providers licensed and trained to deliver them – psychologists and specially trained social workers and counsellors among them. We need to evaluate all steps of service delivery to ensure we don't just give more people access to care but that we give them more access to care that works.

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About the Canadian Psychological Association (CPA): The 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.

The CPA's mandate is to: 1) improve the health and welfare of Canadians; 2) promote excellence and innovation in psychological research, education and practice; 3) promote the advancement, development, dissemination and application of psychological knowledge; and 4) 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/Press%20Release/CPA_HealthAccord_PressRelease.pdf
[ii] http://www.cpa.ca/docs/File/Press%20Release/CPA_PressRelease_HealthAccord_Dec20.pdf
[iii] http://www.cpa.ca/docs/File/Position/An_Imperative_for_Change.pdf
[iv] http://www.cpa.ca/docs/File/Government%20Relations/Targeting%20funds%20for%20better%20access%20to%20quality%20mental%20health%20care%20for%20Canadians%20February%202017final.pdf
[v] http://strategy.mentalhealthcommission.ca/strategy/summary/
[vi] http://www.cpa.ca/docs/File/Practice/TheEfficacyAndEffectivenessOfPsychologicalTreatments_web.pdf ; http://www.cpa.ca/cpasite/UserFiles/Documents/publications/Cost-Effectiveness.pdf
[vii] http://www.cpa.ca/docs/File/Press%20Release/Mental%20Health%20joint%20letter%20Jan%202017%20CFPC%20CPA.pdf
[viii] http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf
[ix] https://aims.uw.edu/collaborative-care/principles-collaborative-care [x] http://www.health.gov.au/mentalhealth-betteraccess
[xi] https://www.england.nhs.uk/mental-health/adults/iapt/
[xii] Personal communication December 2015, Dr. David Clark, developer of the UK's IAPT
[viii] http://www.cpa.ca/docs/File/Position/An_Imperative_for_Change.pdf
[xiv] http://www.lets-talk-iapt.nhs.uk/refer/