Canadian Centre on Substance Use and Addiction | Centre canadien sur les dépendances et l'usage de substances

Canada Health Infoway | Inforoute Santé du Canada

Mental Health Commission of Canada | Commission de la santé mentale du Canada

Leveraging Technology to Address Mental Health and Substance Use in Canada

Meeting Summary Report

Roundtable held on Thursday, November 16, 2017
Calgary, Alberta

Prepared by
Adair Roberts & Associates

Mental Health Commission of Canada, Canadian Centre on Substance Use and Addiction, and Canada Health Infoway Roundtable
Leveraging Technology to Address Mental Health and Substance Use in Canada

Thursday, November 16, 2017
Calgary, Alberta

Mental Health Commission of Canada
Canadian Centre on Substance Use and Addiction
Canada Health Infoway

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This document is available at http://www.mentalhealthcommission.ca
Production of this document is made possible through a financial contribution from Health Canada.

Executive Summary

Mental Health Commission of Canada, Canadian Centre on Substance Use and Addiction and Canada Health Infoway Roundtable
Leveraging Technology to Address Mental Health and Substance Use in Canada

Thursday, November 16, 2017
Calgary, Alberta

People with lived experience of mental health and substance use, policy-makers, researchers, and service providers, have identified the potential of technology-based interventions (TBI) to extend the reach of, access to, and quality of mental health and substance use services in Canada. Currently, how to select, best leverage and scale-up TBI is the subject of much discussion, debate and research in jurisdictions across the country.

The Mental Health Commission of Canada (MHCC), the Canadian Centre on Substance Use and Addiction (CCSA) and Canada Health Infoway (Infoway) partnered to co-host a roundtable on November 16, 2017, focused on leveraging technology to address mental health and substance use in Canada, including the opioid and youth suicide crises.

The objectives of this roundtable were to:

- discuss opportunities and specific actions for TBI to address emerging mental health and substance use concerns and improve access to care; and,
- identify the most pressing system level and policy changes required to integrate the use of technology into current practice.

In the first of three presentations aimed at setting the context for the day's discussions, Dr. Michael Krausz, Providence Health BC Leadership Chair in Addiction Research, University of British Columbia, proposed that because technology and social media are now so integrated into our daily lives, it is time for a major paradigm shift in how we think about how and what we fund and deliver mental health and substance use services across Canada. Krausz posited that TBI offer many of the right tools to respond to current public health issues such as the youth suicide, overdose and trauma care crises, suggesting that Canada could and should learn from others who are further ahead in their TBI implementation and scale-up journeys, translating their lessons learned into Canadian practice.

Clare Perry, Group Manager, Integrated Service Design, Ministry of Health, New Zealand and Andrew Slater, CEO, Homecare Medical, co-presented a case study on the design, planning and implementation of New Zealand's National Telehealth Service. Perry shared her perspective as the government leader of the initiative, explaining that New Zealand's success in this area has come about in significant part from the approach the government took in commissioning the service.

Slater spoke from the perspective of the service provider, describing what the National Telehealth Service does, how it is organized, and the factors that have been critical to its success (which include thinking nationally while acting locally, use of high-trust, outcome-focused, long-term contracts, partnering with expert providers, and extreme leveraging of social media).

Following the presentations, participants placed their jurisdiction on a continuum of TBI implementation and scale-up, from conception (thinking about TBI, not yet acting) to maintenance (full scale-up, evaluation and quality improvement) for each of their mental health and substance use systems. After getting a picture of "where things are at" across the country, participants discussed facilitators and barriers to further progress, and shared their ideas and recommendations as to the system-level changes needed to move jurisdictions and Canada along the implementation and scale-up continuum.

Overall, seventeen (17) required elements for sustained advancement of TBI in Canada emerged, including:

1. **broad awareness** of TBI availability and potential;
2. clearly **defined objectives** and areas of focus;
3. **co-design** of the TBI strategy, implementation and monitoring process **with people with lived experience**;
4. **political will, strong leadership**, and well-placed **champions and change agents** at all levels of the system who collaborate to develop a national **TBI strategy and portal/platform**;
5. development of new **long-term funding/commissioning models** and reduction in funding of one-off, short-term pilot projects;
6. organization of the service delivery system using a **stepped care model**[1] within each jurisdiction;
7. generation and use of **data to drive decision-making**;
8. **increased tolerance for risk**, experimentation and failure;
9. **collaboration and values- and trust-based partnerships** across levels of government, sectors and industries;
10. **different innovation models to guide how research is conducted** and knowledge is disseminated/transferred;
11. assurance of **privacy and confidentiality**;
12. **policy alignment** (e.g., legislation, regulation, licensing, policy);
13. increased use of **implementation science**;
14. **strategies to bridge the digital divide**, both generational and geographical;
15. investment in **education, training and capacity-building** for service providers and communities;
16. address **healthcare and e-health governance**; and,
17. **workflow (re)alignment**.

1 A stepped care model presents patients with the most effective and least resource intensive supports first (e.g., an initial consultation, single therapy session, online self-help resources) and as needed, facilitates their connection to more intensive levels of care (e.g., intensive therapy, psychiatric consultation, and/or system navigation and referral to tertiary services).

Participants also focused on what they felt was one of the greatest barriers to progress – a strong aversion to risk on the part of policy-makers and funders – suggesting five strategies to shift the risk paradigm in Canada:

- put people with lived experience front and centre of the entire process, engaging in true co-design and ensuring they speak directly with decision-makers, policy-makers and funders;
- reframe the risk by documenting and communicating the real cost of not changing and re-orienting the system from "ruling people out" to "ruling people in" through universal design;
- use contracting to better manage risk by placing risks with those best positioned to manage them;
- bring national organizations (e.g., MHCC, CCSA, Infoway, others) together with a mandate to scope out what it will take to implement and scale-up TBI in Canada; and,
- change how funding/commissioning is done by bringing federal, provincial and territorial governments together to align and change the funding model(s)/commissioning structure(s) used in this area.

The meeting concluded with MHCC, CCSA and Infoway committing to use the content of the day's discussion to inform their work going forward, as well as identifying areas for future collaboration, particularly in regard to their collective knowledge translation and exchange activities.

Contents

"If web-based medicine is the backbone of the future mental health system, start building it. This change needs to be disruptive, not incremental, and it starts with a different [way of] thinking."

Dr. Michael Krausz
Providence Health BC Leadership
Chair in Addiction Research
University of British Columbia

"...the greatest risk we face as a nation is that 90% of those who need care are not receiving it."

Participant

Introduction

Over the last few years, the Mental Health Commission of Canada (MHCC), the Canadian Centre on Substance Use and Addiction (CCSA) and Canada Health Infoway (Infoway) have each brought together stakeholders to explore the potential for technology-based interventions (TBI) to transform the delivery of mental health and substance use service delivery in Canada.

In recognition of their shared interest in this area, the MHCC, CCSA and Infoway co-hosted a roundtable in November 2017 on leveraging technology to address mental health and substance use in Canada. Leveraging the expertise, skills and contacts of the host organizations, this roundtable was organized to bring together policy-makers, researchers, national associations, and people with lived experience to identify concrete priorities for action to implement and scale-up TBI in Canada. More specifically, the objectives of this roundtable were to:

- discuss opportunities and specific actions for TBI to address emerging mental health and substance use concerns and improve access to care; and
- identify the most pressing system level and policy changes required to integrate the use of technology into current practice.

The desired outcomes of this roundtable were that:

- participants identify the key actions and changes required to enhance technology use in mental health and substance use services delivery; and,
- the MHCC, CCSA and Infoway draw on the discussion and outcomes of this meeting to inform and advance, their respective work in this area, including potential collaborative efforts.

To prepare participants for the meeting, two recent reports produced by the MHCC were shared, which summarized implementation and literature on e-mental health: *Advancing the Evolution: Insights into the state of e-Mental Health Services in Canada* and *RE-AIMing e-Mental Health: A Rapid Review of Current Research*. The literature also refers to TBI for substance use. As the research shows, TBI is less developed for substance use than mental health care.

The purpose of this report is to provide a summary of the key points made during the roundtable. The intended audience for this summary includes decision makers, health authorities, health care providers and policy makers. See Appendix A for the day's agenda, Appendix B for the list of session participants, and Appendix C for biographies of the presenters.

TECHNOLOGY-BASED INTERVENTIONS…

…include "mental health [and substance use] services and information delivered or enhanced through the Internet and related technologies."*

While there is no universal definition for technology-based interventions (nor e-Mental Health, e-Addictions), the MHCC, CCSA and Infoway adopted and adapted the above quote from Christensen, Griffiths and Evans because it is broad enough to account for the constant evolution of technology.

* Christensen, H., Griffiths, K., & Evans, K. (2002). E-Mental Health in Australia: Implications of the Internet and Related Technologies for Policy. ISC Discussion Paper No 3, Commonwealth Department of Health and Ageing, Canberra.

"As health policy-makers and providers, we clearly need to respond very differently than in the past…[our strategy] emphasizes a strong focus on health consumers, the need for more services in the community, a stronger push on prevention and early intervention, and new innovative ways of reaching our most vulnerable."

Clare Perry
Group Manager, Integrated Service Design
Ministry of Health, New Zealand

Technology-based Interventions in Mental Health and Substance Use: Needs, Opportunities and Impact

The meeting's presentations identified what is needed to achieve implementation and scale-up of technology-based interventions and showcased a successful example of implementation and system integration of technology-based interventions (TBI) in New Zealand from the perspectives of a government leader and industry innovator.

What's needed to achieve what's possible

Dr. Michael Krausz proposed that because technology and social media are now so integrated into our daily lives, it is time for a major paradigm shift in how we think about how and what we fund and deliver mental health and substance use services across Canada. Krausz posited that TBI offer many of the right tools to respond to current public health crises such as the youth suicide, overdose and trauma care crises. He further suggested that Canada could and should learn from others who are further ahead in their TBI implementation and scale-up journeys, translating their lessons learned into Canadian practice.

Dr. Krausz outlined some of the key issues facing Canada's mental health and substance use systems including insufficient access to mental health and substance use services (only a small minority of people who need such services can access them); inequitable access to service, particularly for those in Canada's rural and remote communities; and uneven quality of service across local communities and the country. He also described three of Canada's public health emergencies: the youth suicide crisis (nearly 10% of youth experience suicidal ideation, with significantly higher rates in remote communities); the overdose crisis (overdose is now the main reason for mortality in the young adult age group); and rising trauma rates (due in part to growing numbers of the forcefully displaced around the world).

Technology can be used to help address the overdose crisis by: supporting informed decision-making on the risks associated with using a substance supporting the delivery of peer counseling and mentoring services; lowering barriers to access and engagement with treatment options; addressing concurrent disorders like trauma and depression; and targeting high-risk populations.

PRESENTERS

Dr. Michael Krausz
Providence Health BC Leadership Chair in Addiction Research, University of British Columbia

Ms. Clare Perry
Group Manager, Integrated Service Design, Ministry of Health, New Zealand

Dr. Andrew Slater
CEO, Homecare Medical, New Zealand

Dr. Krausz states that access to trauma-based care can be significantly enhanced through TBI. Examples include interactive online trauma programs, online self-assessments and tools to support informed decision-making, delivery of peer counseling and ongoing mentoring in people's original language, and the provision of virtual medical care and expert advice through "virtual clinics".

Dr. Krausz made three assertions – related to time, capacity and access – which he says point to the need for a major change in how we select, fund and deliver mental health and substance use services. These assertions include that:

- it will be impossible to **respond** to public health emergencies in time without web-based resources;
- it is impossible to build quick **capacity** without web-based resources; and,
- it is proven to be impossible to serve remote areas without online strategies **(access)**.

Case example of successful implementation and integration

Clare Perry and Andrew Slater co-presented a case study on the design, planning and implementation of New Zealand's National Telehealth Service. Perry shared her perspective as the government leader of the initiative, explaining that New Zealand's success in this area has come about in significant part from the approach the government took in commissioning the National Telehealth Service (the term telehealth encompasses what is often named e-health, e-mental health, m-health, or virtual health in other jurisdictions). Slater spoke from perspective of the service provider, describing what the National Telehealth Service does, how it is organized, and the factors that have been critical to its success, including thinking nationally while acting locally, use of high-trust, outcome-focused, long-term contracts, partnering with expert providers, and extreme leveraging of social media.

Perry described how the current system was not working well for everyone, leading to health disparities. There were calls for greater public involvement in design and a move to "co-design" rather than "consumer representative design." There was also a growing recognition that many health outcomes could not be solved by one government agency or provider operating independently, and that commissioners and providers working together to determine good quality measures could raise the quality of the service and enhance working relationships.

The Commissioning Service ran a competitive dialogue procurement process (over a two-year period. Through a co-design process with people with lived and living experience, hospitals, community health providers, primary care providers, police, and others, the Commissioning Service developed the specifications and contracting approach for the new National Telehealth service.

The National Telehealth contract was unique in that it was granted for a ten-year term, funded by multiple agencies, and founded on the principles of innovation, sector engagement, and operating and financial transparency. Perry highlighted the critical importance of a multi-year funding structure with fewer restrictions when working on high-complexity issues. Such an approach recognizes that making changes takes significant time and organizations need some freedom to respond to the changes in the context in which they work.

Perry concluded by outlining the key principles that underpin health service design and delivery in New Zealand:

- acknowledge the special relationship between Maori, the indigenous peoples of New Zealand, and the Crown;
- enable best health and well-being possible for all;
- improve health status of those experiencing disparities;
- actively build positive relationships – recognize the value of trust;
- integrate the design/delivery of services around clients' needs;
- partner with people and communities;
- think beyond narrow definitions of health when collaborating;
- focus limited funding on the biggest overall impact (system and scale); and,
- make the best use of collaborative health promotion, rehab and disease/injury prevention.

Andrew Slater then shared the ambition of the National Telehealth Service provided by Homecare Medical, which is "to virtually support kiwis (New Zealanders) to stay well and connect them seamlessly with care when they need it." The Service is funded by two Primary Care Trusts (social enterprises) that receive a return for their investment. The Service has eight Clinical Teams[2] that deliver care 24/7 across seven delivery channels (including phone, text, email, group, face-to-face). The Service has an innovation fund which is used to develop and test new concepts and services.

Services are conceived of as a funnel, increasing in clinical richness and cost the further down toward the narrow end of the funnel that you go, and include:

- **public information campaigns** (website self-help, social media channels, media);
- **personalized automated advice** (assessments, symptom checkers, monitoring, targeted marketing, apps);
- **online interaction** (chat, email, text, social messaging);
- **personal interaction** (phone, picture, video); and,
- **face-to-face referral** (ambulance, afterhours service, hospital, counselling and advice service, community service, homecare, and supported selfcare service).

Slater said that fundamental to the success of the Service is a high-performing workforce, supported by strong personnel management and clinical governance processes. Clinical governance processes include training, e-learning and monthly online learning requirements, clear policies and procedures, professional development and registration requirements, investigation and root cause analysis processes, trend analysis, service reviews, and an external Clinical Governance Committee.

2 Nurses, Mental Health and Addiction Specialists, Health Advisors, Poisons Officers, Emergency Triage Nurses, Mental Health Nurses, Sexual Violence Counsellors and Population Health Practitioners

Slater described Homecare Medical's unique competencies:

- **user experience-based co-design** detailed profiles of key consumer segments and use of social media to engage New Zealanders in regular co-design efforts;
- **social marketing** campaigns targeting its key segments, thinking nationally but "acting locally" by getting local communities to help market the Service's various channels and programs to each other; and,
- **relentless focus on outcomes** with clear definition and measurement of outcomes, consistent reporting and follow-up.

Slater finished with some final thoughts on what systems need to do to fully embrace and drive TBI implementation and scale-up, as listed below:

- invest heavily in clinical leadership;
- think "national" but act "local" – use technology to empower communities;
- privacy and confidentiality-related issues – just sort them out;
- see "digital" as a product, not a project;
- recognize that you have the skills you have – partner deeply to get other needed capabilities;
- change how you commission (fund, contract) to drive change
- get to scale;
- use less specific, high-trust, outcome-focused, long-term contracts;
- see marketing and promotion as a digital service delivery; and,
- see helplines as a foundation for future change.

"Think national but act local. Get communities to help market different channels, programs and solutions."

Andrew Slater
CEO, Homecare Medical

How Can Canada Effectively Implement and Scale-up Technology-based Interventions?

Participants discussed where their jurisdiction currently is regarding TBI implementation and scale-up for each of their mental health and substance use systems (recognizing that each may be in different places). The continuum used included five stages:

- **conception**: Thinking about and contemplating TBI implementation but not yet acting in this area;
- **strategy development**: Inclusion of TBI in strategic plans of government and organizations;
- **adoption**: Early operationalization of TBI strategies and action plans;
- **implementation**: Wide-scale implementation and operation of TBI across the mental health and substance use system; and,
- **maintenance**: Steady-state operation, evaluation, continuous improvement and selective termination of TBI initiatives.

Some participants indicated that it was hard to determine where their jurisdiction was along the continuum as a couple of categories "fit" depending what part of the mental health and substance use systems were being considered. Nevertheless, there were some identifiable clusters, for example:

- mental health systems seemed, in general, to be placed further along the TBI implementation and scale-up continuum than substance use systems;
- most jurisdictions and organizations were clustered around the earlier "Conception" and "Strategy Development" stages of the implementation and scale-up continuum; and,
- the remaining jurisdictions were clustered under the "Adoption," "Implementation" and "Maintenance" segments of the continuum (with the jurisdictions under "Maintenance" typically referencing crisis line/telephone implementation in particular).

Having reflected on where their jurisdiction was along the continuum, participants then identified factors that facilitated their progress to-date along the continuum, barriers they have faced on the journey to-date, and what is needed to drive continued implementation and scale-up of TBI.

Facilitators to progress

Participants were quick to identify a number of facilitators of TBI implementation and scale-up; these included:

- **political** will from the highest levels, progressive **leadership**, and placement of **change agents** at all levels of the system;
- clarity around **definitions, outcomes, deliverables** and **accountabilities** over time;
- flexibility in **funding models** (and commissioning structures) used, including models not currently used widely in the health care system;
- **co-design** of TBI strategies and implementation plans;
- **external partnerships** (inter-agency, corporate) based on common values, behaviours and trust, and used to close capability gaps (i.e., honesty about organization and system capacity and capabilities);
- **social media** and **community mobilization** to extend reach and scale of TBI implementation; and,
- interest from **researchers** and **consumer social activism** to stimulate and sustain momentum for change.

Barriers to progress

Participants also identified a number of barriers to progress in advancing TBI, including:

- **traditional government funding models** and commissioning structures, both Ministry and Health Authority (which are influenced by a risk averse culture, would benefit from clearer definition of and focus on appropriate outcome measures and have a tendency toward pilot projects which often have limited capacity for replication and scale-up);
- challenges crossing **inter-jurisdictional, inter-Ministerial, and cross-sectoral boundaries**;
- **privacy and confidentiality** issues and concerns;
- **consumer reticence or inability** to engage in technology-mediated services (due to cultural safety, technological competence, financial barriers or other reasons);
- use of **traditional research methods** to evaluate the effectiveness and efficiency of TBI (when, in fact, the technology has already changed by the time the research is completed and disseminated); and,
- feeling **overwhelmed** in terms of how to start and knit what often is a multitude of projects and initiatives together.

What is needed to drive and sustain progress: top priorities, actions and recommendations

Attendees reviewed, discussed and developed a draft list of what is needed to drive and sustain progress in TBI implementation. During the discussions, 17 required elements for sustained advancement of TBI in Canada emerged, the relative emphasis among which varies depending on the specific outcomes desired and jurisdictional context and readiness. These elements include:

1. **broad awareness** of TBI availability and potential (achieved in part through wide-scale dissemination of the evidence for/availability of TBI and on-the-ground local engagement and capacity-building);
2. **clearly defined objectives** and areas of focus;
3. **engagement and co-design** of the TBI strategy, implementation and monitoring processes **with people with lived experience** which would include fully embracing the concept of person-led care;
4. **political will**, strong **leadership**, and well-placed **champions** and **change agents** at all levels of the system who collaborate to develop a **national TBI strategy and portal/platform** that can be leveraged in ways relevant to each jurisdiction[3];
5. **development of new funding/commissioning models** that take a long-term perspective, involve government, industry and social enterprise, and include innovation in corresponding infrastructure planning, allocation and accountability frameworks (with a corresponding reduction in the funding of one-off, short-term pilot projects);
6. **organization of the service delivery system** using a **stepped care model**[4] within each jurisdiction, incorporating relevant TBI at each step;
7. **generation and use of data to drive decision-making**;
8. significantly increased **tolerance for risk, experimentation and failure**;
9. **collaboration** and trust-based partnerships **– based on common values – across levels of government, sectors and industries** (to secure needed expertise, and particularly regarding technology partnerships);
10. **different innovation models** to guide how **research** is conducted and knowledge is disseminated/transferred (i.e., changes to existing academic-based research structures/ models);
11. **assurance of privacy and confidentiality**;
12. **policy alignment** (e.g., legislation, regulation, licensing, policy);
13. increased use of **implementation science** (i.e., knowing and using what works to support successful implementation and scale-up of TBI);
14. strategies to **bridge the digital divide**, both generational and geographical (including development of a national strategy with local implementation plans and tactics);
15. investment in **education, training and capacity-building for service providers and communities**;
16. addressing of **healthcare and e-health governance** issues (e.g., alignment of objectives and outcomes, authority and accountability across levels of government, organizations and jurisdictions); and,
17. **workflow (re)alignment**.

3 While the strategy needs to be long-term, some participants felt that it should be supported by rolling 100-day implementation plans, as done in New Zealand, to ensure rapid pace and accountability for results.

4 A stepped care model presents patients with the most effective and least resource intensive supports first (e.g., an initial consultation, single therapy session, online self-help resources) and as needed, facilitates their connection to more intensive levels of care (e.g., intensive therapy, psychiatric consultation, and/or system navigation and referral to tertiary services).

"Is what we're talking about doing here really going to get us there, or are we just making suggestions about how to extend what we are already doing? Maybe we're too risk-averse and we just need to be more provocative."

Participant

Priorities for Action

The final portion of the meeting was designed for participants to align, where possible, around priorities for action. The discussion evolved into a conversation about one of the greatest barriers to progress – a strong aversion to risk on the part of policy-makers and funders, which inhibits innovation needed to make significant progress in the implementation and scale-up of TBI.

Participants identified concrete ways to work towards shifting the risk paradigm in Canada:

- **Listen to people with lived and living experience:** Put people with lived and living experience front and centre of the entire process – engage in true co-design and ensure they speak directly with decision-makers, policy-makers and funders.
- **Reframe the risk:** Document and communicate the real cost of not changing. Re-orient the system from "ruling people out" to "ruling people in" through universal design; in the words of one participant "the greatest risk we face is that 90% of those who need care are not receiving it." Shift the focus to the 90% of people who need but are not getting care, focus on building overall wellness. Implement stepped care models to ensure the right people get connected to the right services at the right time.
- **Use contracting to manage risk:** Use contracting of services effectively to place various risks with those best positioned to manage each risk (and be ready to apologize when things go wrong, as they will from time to time). Partner on capabilities so that risks are managed by those most skilled and able to handle them.
- **Ensure national organizations plan together:** Bring national organizations (e.g., MHCC, CCSA, Infoway, others) together to plan together and assist jurisdictions to situate themselves within the national conversation. Mandate the national organizations to work together to scope out what it will take to implement and scale-up TBI in Canada.
- **Change how funding/commissioning is done:** Bring federal, provincial and territorial governments together to align and change the funding model(s)/commissioning structure(s) used in this area. Name TBI as a national priority to be implemented and scaled up in collaboration with provinces and territories.

"It will be impossible to respond to public health challenges without web-based resources. It is impossible to build quick capacity without web-based resources. It is proven to be impossible to serve remote areas without online strategies."

Dr. Michael Krausz
Providence Health BC Leadership
Chair in Addiction Research
University of British Columbia

Conclusion and Next Steps

Technology-based interventions (TBI) have the potential to extend the reach of, access to and quality of mental health and substance use services in Canada. The outcomes from this roundtable identified key opportunities and barriers with respect to effectively leveraging technology to address mental health and substance use issues in Canada. A key area identified for collaboration was knowledge translation and exchange including advancing the conversation about TBI in order to raise awareness with key influences such as policy makers and health authorities, and promoting best evidence for TBI in mental health and substance use service delivery.

MHCC, CCSA and Infoway are committed to using the content of the day's discussions to inform their work in this area going forward, as well as identifying areas for future collaboration.

Appendix A: Meeting At A Glance

8:30 am – 4:00 pm, Thursday, November 17, 2017, The Westin Calgary, Calgary, Alberta

ITEM	SPEAKER
Arrivals and Breakfast	
Opening	**Elder Casey Eagle Speaker**
Introduction and Kick-off	**Nicholas Watters**, Director, Knowledge Exchange Centre Mental Health Commission of Canada **Adair Roberts,** Facilitator, Adair Roberts & Associates
Technology-based Interventions in Mental Health and Substance Use: Needs, Opportunities and Impact	**Dr. Michael Krausz**, Providence Health Care BC Leadership Chair in Addiction Research, University of British Columbia • How technology-based interventions can improve access to and quality of mental health and addiction treatment services • The need for innovative approaches to address emerging areas of concern in mental health and substance use **Clare Perry**, Group Manager, Integrated Service Design, Ministry of Health, New Zealand **Andrew Slater,** CEO, Homecare Medical (where?) • Case study on successful implementation and system integration of technology-based interventions for mental health and substance use in New Zealand from the perspectives of a government leader and industry innovator
Health Break	
Facilitated Discussion: How Can Canada Effectively Implement and Scale-up Technology-based Interventions?	**Facilitated by Adair Roberts**, Adair Roberts & Associates
Lunch and networking	
Roundtable Discussions: Identify and Share Top Priorities, Actions and Recommendations to Advance Technology-based Interventions in Canada	**Facilitated by Adair Roberts,** Adair Roberts & Associates, **Mental Health Commission of Canada, Canadian Centre on Substance Use and Addiction, and Canada Health Infoway**
Health Break	
Facilitated Discussion: Priorities for Action, Jurisdictional Commitments and Roles for National Organizations	**Facilitated by Adair Roberts**, Adair Roberts & Associates
Final Remarks and Closing	**Adair Roberts**, Facilitator, Adair Roberts & Associates **Nicholas Watters**, Director, Knowledge Exchange Centre Mental Health Commission of Canada
Meeting adjourns	

Appendix B: List of Participants

Participants

NAME	TITLE	ORGANIZATION
Kimberlee Barro	Executive Director, Risk Management & Health Promotion, Nova Scotia Department of Health & Wellness	Government of Nova Scotia
Nigel Bart	Hallway Group Representative	Mental Health Commission of Canada – Hallway Group
Sara Chorostkowski	Manager, Mental Health & Addictions	Government of the Northwest Territories
Marion Cooper	Executive Director	Canadian Mental Health Association – Manitoba
Peter Cornish	Associate Professor & Director, University Counselling Centre	Memorial University of Newfoundland
Linda Courey	Senior Director, Mental Health & Addictions	Nova Scotia Health Authority
Michelle Craig	Executive Director, Addiction & Mental Health, Alberta Health Services	Government of Alberta
John Dick	Hallway Group Representative	Mental Health Commission of Canada – Hallway Group
Todd Evans	Senior Advisor, Substance Use & Addictions Program	Health Canada
Marie Fast	Clinical Manager, Mental Health Services	Government of Yukon
Catherine Ford	Senior Policy Advisory, Mental Health & Addictions, Ministry of Health & Long-Term Care	Government of Ontario
DeAnn Hunter	Director, Addiction and Mental Health	Alberta Health Services
Jill Kelland	Director, Young Adults & Cross Level Services	Alberta Health Services (Edmonton Zone, Addiction and Mental Health)
Kimberly Korf-Uzan	Project Director, Correctional Health Services, British Columbia Mental Health & Substance Use Services	Government of British Columbia
Carolina Koutras	Team Lead, Projects & Initiatives	Canadian Institutes for Health Research Institute of Neurosciences, Mental Health and Addiction
Greg Kyllo	National Director, Program Innovation	Canadian Mental Health Association – National
Niki Legge	Consultant, Government of Health and Community Services	Government of Newfoundland and Labrador
Patricia Lingley-Pottie	President and CEO	Strongest Families Institute
Opal Mcinnis	Assistant Director, Mental Health & Addictions	Government of Nunavut

Participants (cont'd)

NAME	TITLE	ORGANIZATION
Charmaine McPherson	Executive Director, Nova Scotia Department of Health & Wellness	Government of Nova Scotia
Sheryl Pederson	Advisory Council Representative	Mental Health Commission of Canada – Advisory Group
Breanna Pottie	Coach Supervisor	Strongest Families Institute
Fraser Ratchford	Group Program Director	Canada Health Infoway

Facilitator

NAME	TITLE	ORGANIZATION
Adair Roberts	Facilitator	Adair Roberts & Associates

Speakers

NAME	TITLE	ORGANIZATION
Michael Krausz	Professor of Psychiatry, Epidemiology and Public Health	University of British Columbia (UBC)
Clare Perry	Group Manager, Integrated Service Design, Ministry of Health	Government of New Zealand
Andrew Slater	CEO	Homecare Medical

Staff

NAME	TITLE	ORGANIZATION
Christopher Canning	Manager, Policy & Research	Mental Health Commission of Canada
Romie Christie	Manager, Anti-Stigma Initiatives	Mental Health Commission of Canada
Pam Kent	Associate Director of Research	Canadian Centre on Substance Use and Addiction
Shelagh Maloney	Vice President, Consumer Health, Communications and Evaluation Services	Canada Health Infoway
Rhowena Martin	Deputy CEO	Canadian Centre on Substance Use and Addiction
Robyn McQuaid	Research and Policy Analyst	Canadian Centre on Substance Use and Addiction
MaryAnn Notarianni	Manager, E-Mental Health	Mental Health Commission of Canada
Meg Schellenberg	Program Manager, E-Mental Health	Mental Health Commission of Canada
Nicholas Watters	Director, Knowledge Exchange Centre	Mental Health Commission of Canada

Appendix C: Presenter Biographies

Dr. Michael Krausz

Dr. Michael Krausz began his professional career in Germany, where he was trained at the University Medical Center Hamburg-Eppendorf as a registered nurse. He then went on to complete a residency in Adult Psychiatry and his Doctor of Philosophy, where he examined the associations between psychosis and addictions. In the mid-1990s, he became a founding director of the Centre of Interdisciplinary Addiction Research at the University of Hamburg. As founding director, he was responsible for the German Heroin Trial, the European Cocaine Project and several other notable addiction-related trials. He also served as Editor-in-Chief for two European scientific journals–*Suchttherapie and European Addiction Research*.

Krausz relocated permanently to Vancouver, Canada in 2007. From 2009–2012, he was the Medical Director of the Burnaby Centre for Mental Health and Addiction with Vancouver Coastal Health. Currently, he is a Professor of Psychiatry at the University of British Columbia (UBC) and is the Providence Health Care B.C. Leadership (LEEF) Chair in Addiction Research at the UBC Institute of Mental Health. As head of the Addictions and Concurrent Disorders Group at CHEOS, Krausz's research explores the relationship between early life trauma, substance use disorders, and other mental illnesses. His research includes the *At Home/ Chez Soi* study, the B.C. Health of the Homeless Survey and the Study to Assess Long-Term Opioid Maintenance Effectiveness (SALOME). He has published more than 300 scientific papers to date.

More recently, Krausz has extended his expertise to include e-Mental health. The Bell Youth Mental Health IMPACT Project (2012) was his first endeavour in this area. Bell Canada's philanthropic support in the amount of $1 million as part of their Let's Talk Initiative was critical seed funding in the development of a new mental health platform, WalkAlong, designed to provide youth who are experiencing depression and anxiety with resources to help foster mental wellness. In 2014, he was recognized for his tireless research and advocacy related to substance use, mental health and housing security with the City of Vancouver's Healthy City for All Award of Excellence.

Ms. Clare Perry

Clare Perry started her career in the health and disability system as a graduate nurse, working in a range of hospital and community settings in New Zealand and overseas. Her experience includes specialist nursing roles in paediatric and adult transplantation units, as well as in GP practices, Well Child, telehealth and child protection services.

In 2011, Perry managed the Ministry of Health New Zealand's Electives and National Services teams before becoming Group Manager, Integrated Service Design, Service Commissioning in 2016. The Integrated Service Design teams design, deliver and implement services around people's needs with a focus on strengthening health outcomes that are delivered in an equitable and sustainable manner. Perry works across the Ministry, and with both crown agencies and NGOs, to design, plan and fund services.

Dr. Andrew Slater

Slater's background is in the health sector where he has held roles in transformation, strategy, human resources and change management. He first got involved with Homecare Medical to develop their telehealth and mHealth strategy and is now fully onboard as Homecare Medical's first CEO. In this strategic and operational leadership role, Slater is responsible for realizing the vision the Government of New Zealand has for the new national telehealth service. He played a key role in leading the 'transition' team to fully integrate services.

He is now focused on expanding the capacity and reach of health, wellness and mental health services to enable all New Zealanders to access quality care and support within their community in a way that is relevant to them personally. He is also responsible for ensuring Homecare Medical continues to be a trusted service, seamlessly connecting people with the right care and support. In its first year of operation the 300-person Homecare Medical team has provided support to one in ten New Zealanders.

Before joining Homecare Medical, Slater had a strategic leadership role in a health start-up, which specializes in real-time health monitoring technology. Prior to this he was responsible for planning, service development and transformation for New Zealand's Ambulance Service. In this role, he led the development of the first national plan for the ambulance service, including health sector engagement and integration.

In his roles, Slater's focus is always on doing the right thing for patients and the sector, a passion for better, being motivated by quality, and *pokohiwi ki pokohiwi* (standing shoulder-to-shoulder). In 2016, he was a finalist for New Zealand's Young Executive of the year and received the Auckland University of Technology eHealth Innovation Leadership Award. He has been described as a disruptive visionary, which is true, but makes him cringe.

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Financial contribution from

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