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# Options for improving access to counselling, psychotherapy and psychological services for mental health problems and illnesses

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## Options for improving access to counselling, psychotherapy and psychological services for mental health problems and illnesses

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### **Mental Health Commission of Canada**

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## Introduction

In 2012, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* advanced two recommendations to enable wider and more equitable access to counselling, psychotherapy and psychological services for mental health problems and illnesses:

- 3.2.4 Increase access to psychotherapies and clinical counselling by service providers who are qualified to deliver approaches that are based on best available evidence.
- 3.2.5 Remove financial barriers for children and youth and their families to access psychotherapies and clinical counselling.<sup>(17)</sup>

Robert Salois, the Quebec Commissioner for Health and Well-Being, concluded his review of the case for improving access to psychotherapy by stating that the main issue to be debated was no longer whether such improved access was needed, but rather what means should to be taken to accomplish the task. He wrote:

... given the numerous arguments in favour of psychotherapy, the issue facing Canadian policy-makers is no longer whether to increase access to it, but rather to consider what is the best approach to providing broader and more equitable access to psychotherapy services.<sup>(7)1</sup>

The main purpose of this paper is to help advance the discussion of the options for increasing access to counselling, psychotherapy and psychological services for mental health problems and illnesses. It is important, however, to begin by briefly reviewing the abundant, and widely-accepted, evidence in support of the benefits that would flow from improved access to these services.

## Meeting unmet need

The MHCC reports that up to two thirds of adults and three quarters of children and youth do not access services and supports to help them address their mental health concerns.<sup>(17)</sup> Other statistics bear out the existence of widespread, and at times acute, unmet need. A survey conducted of nearly 1300 attendees at Quebec primary care clinics, found unmet mental health needs in 40% of participants.<sup>(12)</sup> Quebec's institute to promote clinical excellence<sup>2</sup> refers to statistics indicating that, over the course of a year, only 40% of Canadians who reported having a mental health problem consulted a health professional. They also cite a 2001 study of people in Montreal that shows that only 20% of mental health needs were

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Note: This paper does not address distinct issues with regard to funding for, access to, and the provision of counselling, psychotherapies and psychological services for Indigenous peoples and communities. These issues fall alongside the distinct priorities identified by First Nations, Inuit and Métis leadership organizations in the Mental Health Strategy of Canada. MHCC is in the process of exploring with First Nations, Inuit, and Métis national organizations how they wish the MHCC to walk alongside them in addressing these priorities in a manner that respects the nation to nation relationship.

<sup>1</sup> ...la question à laquelle sont confrontés les décideurs publics du Canada n'est maintenant plus de savoir s'il faut rehausser l'accès à la psychothérapie, puisque les arguments en sa faveur sont trop nombreux, mais plutôt d'envisager quelle est la meilleure approche pour fournir un accès élargi et plus équitable aux services de psychothérapie.

<sup>2</sup> Institut national d'excellence en santé et en services sociaux, or INESSS.

met.<sup>(9)</sup> According to new data collected by Children’s Mental Health Ontario, children and youth in urgent need of mental healthcare are waiting up to 1.5 years for treatment in some parts of the province.<sup>(5)</sup>

Counselling, psychotherapy and psychological services are effective, and better access to them would help improve the lives of hundreds of thousands of people. Research conducted over many years has shown that psychological treatment provides significant benefits for around 75% to 80% of people treated.<sup>(7)</sup> Unlike many medications, counselling, psychotherapy and psychological services delivered by qualified professionals do not have any side effects. The evidence also shows that they can have a lasting benefit and that they work well in tandem with pharmacological treatments. Counselling, psychotherapy and psychological services have also proved successful in the treatment of many mental health problems in children and adolescents.

Moreover, many people prefer these types of treatment and support to medication-based treatment. According to the American Psychological Association, several studies show that most patients consulting a general practitioner for emotional or psychological problems prefer to be offered psychotherapy rather than antidepressants.<sup>(7)</sup>

Psychological services also provide value for money. A 1997 study found that the overall cost of 20 sessions of cognitive-behavioral therapy (CBT) for treating depression was 30% less than treatment using antidepressants.<sup>(7)</sup> There are also economic benefits for employers and Canadian society as a whole. Vasiliadis et. al. have recently calculated that a program providing access to stepped care CBT in Canada along the lines of the British Increasing Access to Psychological Therapies program would yield \$2 in benefits to society for every \$1 invested.<sup>(26)</sup> The Washington State Institute for Public Policy reports that the use of CBT to treat depression and anxiety is guaranteed to yield significant savings.<sup>(27)</sup> They estimate that over \$56 could be saved for every dollar invested in the treatment of depression, while for anxiety the comparable figure is just over \$50 saved (see Appendix II).

The Conference Board of Canada estimates that improved treatment of depression among employed Canadians could potentially boost Canada's economy by up to \$32.3 billion a year, while improved treatment of anxiety could boost the economy by up to \$17.3 billion a year. Manulife Canada recently sent a clear signal about how valuable it considers access to psychological services to be by increasing the mental health support benefit it provides employees tenfold, to a maximum of \$10,000 per person per year.

In summary:

1. There is significant unmet need for treatment and support for people living with mental health problems and illnesses and addressing this need will benefit tens of thousands of people individually and the economy as a whole.
2. Psychologically-based treatment and support is effective for many conditions and many people, and is often the preferred treatment choice.
3. Spending on psychologically-based treatment and support is cost effective, both in terms of its cost of delivery relative to other treatment modalities, as well as by providing a positive return on investment for individual businesses and for society as a whole.

## Who provides counselling, psychotherapy and psychological services and who pays for them?

Almost 80% of people with common mental health problems use the services of a family physician.<sup>(6)</sup> Mental health problems account for roughly 50 per cent of family doctors' time, and they are the sole source of support for as many as 84 percent of individuals seeking mental health care.<sup>(1)</sup> According to one study, 89 per cent of family physicians in Canada carry out psychotherapy or counseling and 83 per cent offer mental health assessment and prescribe drugs for mental health difficulties.<sup>(22)</sup>

While family physicians provide many mental health services, medications tend to be the most frequently relied upon method for addressing mental health needs. In 2012, Statistics Canada reported that 91% of patients were able to receive the medications they sought but only 65% reported getting the therapy they wanted.<sup>(1)</sup> The significant usage of pharmacologically-based treatment shows up in the statistics. Almost one in 10 Canadians are on antidepressants (two-thirds of them women) and, in 2013, Canada ranked third highest among 23 countries in the use of anti-depressants, consuming approximately 40 million prescriptions a year.<sup>(1)</sup>

Canadian physicians of all kinds bill provincial governments \$1-billion a year for “counselling and psychotherapy” – one third of which goes to family doctors. This \$361-million a year that family physicians bill for counselling or psychotherapy covers 5.6 million visits of roughly 30 minutes each, although not all of this is for psychotherapy (counselling includes drug counselling).<sup>(1)</sup> In fact, most of the non-pharmacological interventions provided by family physicians primarily entail emotional support and counseling (listening/giving advice) rather than formal psychological treatments. In this regard, a 2007 survey of 163 family doctors in Ontario found that 80% had received no training in cognitive behavioural therapy and knew little about it.<sup>(1)</sup> There is little Canadian data on family physician training in other evidence-based psychotherapies.

This paper follows the MHCC's approach to recovery (most fully articulated in the *Guidelines to Recovery-Oriented Practice*<sup>(18)</sup>). The goal of recovery is to enable people to live meaningful lives in the communities of their choice despite any ongoing challenges associated with the experience of a mental health problem or illness. This approach embraces a holistic view of people and a biopsychosocial understanding of mental health problems and illnesses.

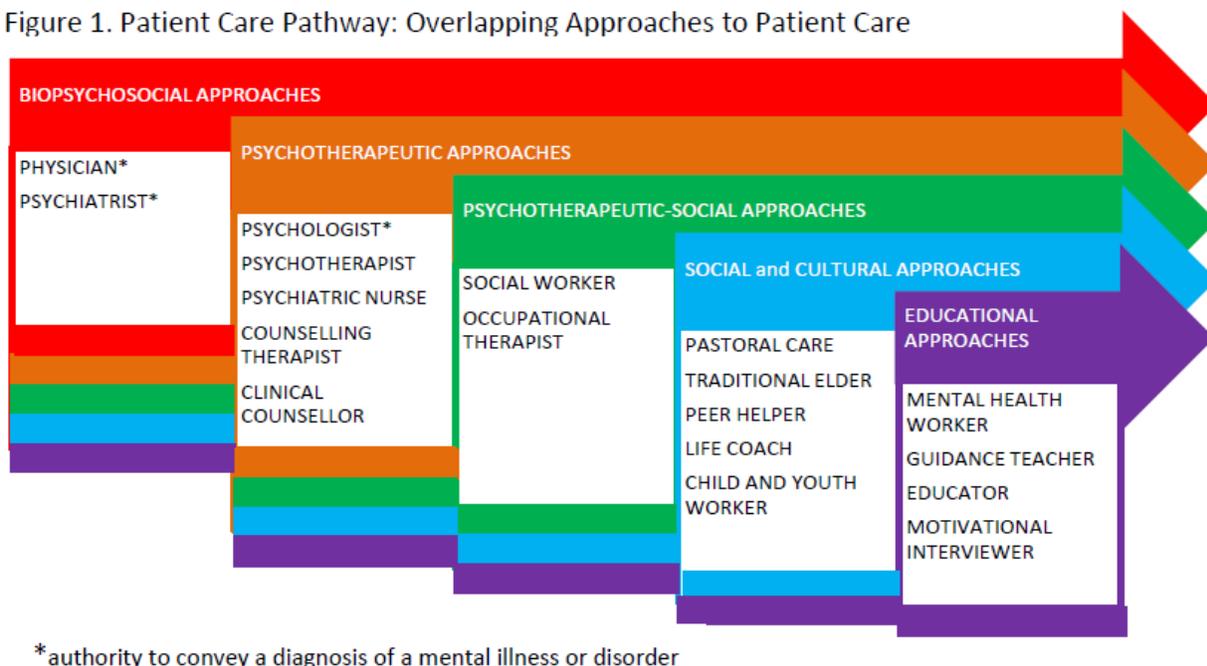
Both pharmacological and non-pharmacological treatment can support people on the road to recovery.<sup>(18)</sup> At its most inclusive, counselling, psychotherapy and psychological services could be thought to encompass any non-pharmacological treatment or support service that assists people on their road to recovery. There are many providers of non-pharmacological services and supports to people living with mental health problems and illnesses in Canada.

Table 1 (see Appendix I) provides an overview of the range of the main providers and services that are available (unevenly) across Canada. Providers of counselling, psychotherapy and psychological services work in many settings ranging from institutions such as hospitals, schools and the corrections system, through primary care practices and community mental health agencies to many types of private practice.

In a paper for the Canadian Counselling and Psychotherapy Association,<sup>(16)</sup> Lorna Martin has provided a figure that illustrates the range and the limits of the scopes of practice of providers of counselling, psychotherapy and psychological services (*Figure 1* below). Providers holding the most inclusive scope of practice are on the left.<sup>3</sup> Other than medical doctors, only clinical psychologists are authorized to provide formal diagnoses of mental illness.

Many providers of counselling, psychotherapy and psychological services are already regulated in all provinces and territories whereas others are only regulated in some and many do not have any certification at all.<sup>(16)</sup> Psychologists, social workers, nurses and occupational therapists are registered in every jurisdiction while psychotherapy (when provided by mental health professionals other than psychologists and clinical social workers) is now regulated in Quebec, Ontario and Nova Scotia but not elsewhere. Many forms of counselling are not regulated in any jurisdiction.

**Figure 1. Patient Care Pathway: Overlapping Approaches to Patient Care**



In order to be eligible for federal funding, the Canada Health Act (CHA) requires provincial health care insurance plans to cover all services provided by doctors or in hospital, including those related to mental health.<sup>4</sup> Psychological services provided by doctors, whether family physicians or psychiatrists, are covered by provincial and territorial health insurance. Services provided in hospital by psychologists or other mental health providers are also publicly funded.<sup>(22)</sup>

While it does not require it, the CHA does not prohibit provinces and territories from funding other mental health services and all of them do to varying extents, as does the federal government.

<sup>3</sup> It is important to bear in mind that, although the scope of practice of providers on the left of the *Figure* “allows” them to do all the kinds of things that are in the scope of practice of the providers to the right of them, individual providers will in practice not be able to deliver the vast majority of them. For example, a physician will usually not deliver any of the treatments delivered by an occupational therapist, even if in principle their scope of practice allows them to deliver “psychotherapeutic-social” approaches.”

<sup>4</sup> The Act defines insured services as “hospital services, physician services and surgical-dental services provided to insured persons.”

Psychologists, social workers, occupational therapists and other mental health workers are employed in hospitals and other provincially operated facilities that provide mental health care and the provinces and territories fund many community agencies that provide psychological services. Correctional Services Canada is the single largest employer of psychologists in the country.<sup>(22)</sup> Some publicly funded primary care group practices also offer access to psychologists or other mental health providers.

Regardless of the type of training or the nature of the service, no provincial or territorial public insurance plan currently permits the reimbursement of providers of counselling, psychotherapy and psychological services who practice outside the public system.<sup>(9)</sup> In 2001, approximately 80% of consultations with psychologists took place within the privately funded system,<sup>(19)</sup> while it has been estimated that Canadians annually spend \$950-million on private practice psychologists' services alone.<sup>(22)</sup> About 30 per cent of this expenditure is funded out-of-pocket, with almost all the remainder coming from employment-based private health insurance plans.

Although about 60 per cent of Canadians have some form of private employment-based insurance, the amount available for therapy may cover only a handful of sessions.<sup>(1)</sup> Typical annual limitations to payments range from \$500 to \$1000, although this varies by plan sponsor. Those with the best benefits are more likely to be higher-income workers with stable employment. This means that low income Canadians, who are much more likely to report being in poor to fair mental health, have less access to counselling, psychotherapy and psychological services.<sup>(1)</sup>

In summary:

1. Only medically necessary services provided by physicians or in hospital are required to be publicly funded in Canada.
2. While all jurisdictions fund some additional mental health services delivered by a range of providers, no province or territory provides universal insurance coverage for counselling, psychotherapy and psychological services.
3. Because counselling, psychotherapy and psychological services provided outside of hospitals are paid using private sources, typically employment-based benefit plans, there is not equitable access to the many types of providers who could be of benefit to people living with mental health problems and illnesses.

## Current limits on increasing access to counselling, psychotherapy and psychological services

The three possible avenues for increasing access to counselling, psychotherapy and psychological services are:

- (i) expanding the amount of coverage afforded by private group insurance plans;
- (ii) increasing the amount of counselling, psychotherapy and psychological services delivered by physicians; and
- (iii) providing public funding to pay for the services of the many providers who are not currently covered under Medicare.

There are significant limits on what the first two options can accomplish. The third option is the most promising, but will require new sources of public funding in order to be possible.

The fact that a number of employers have recently raised the level of benefits available to their employees for mental health is an indication that it is possible to increase access to counselling, psychotherapy and psychological services using private sources of funding. Federal public servants saw their mental health benefits doubled in 2014 to \$2,000 annually while Starbucks announced in 2016 that it would provide up to \$5000 per year. But, as already noted, the most significant increase was by the insurer Manulife which multiplied its employee mental health benefits tenfold to a maximum of \$10,000, also in 2016. However, these increases only benefit a small percentage of the 60% of Canadians with workplace based insurance plans. Even if all private plans followed the lead of the ones mentioned above it would still leave a very large proportion of the Canadian population with limited or no access to counselling, psychotherapy and psychological services.

Expanding access to publicly funded counselling, psychotherapy and psychological services in some fashion will therefore be required. The question is how to go about doing this. It is difficult to see how providers of mental health care who currently receive public funding could successfully expand provision within their existing budgets. To do so, both family and specialist physicians as well as hospitals would have to shift resources from other medical concerns to addressing mental health problems and illnesses.

As we have seen, the vast majority of primary care physicians are not trained to deliver psychological services<sup>(7)</sup> and even if they were able to offer them, this would come at the cost of other medical services they provide. While enabling more primary care physicians to enhance their ability to provide mental health care can be an important component of improving overall mental health outcomes, it will not on its own meet the need for counselling, psychotherapy and psychological services.

For their part, psychiatrists also tend to be over-subscribed. A 2011 study found that in Vancouver only 6 of 230 psychiatrists who were contacted by the researchers were willing to take a referral “immediately,” which still meant that the person had to wait up to 64 days for an appointment.<sup>(1)</sup> As psychiatrists Gratzer and Goldbloom point out:

One of the options for improving access to psychotherapy within a publicly funded system is to increase the number of psychiatrists. This assumes that more psychiatrists automatically means better access... With 4000 psychiatrists currently in Canada, even if each performed 40 hours per week of psychotherapy, that model would provide ongoing care for 160,000 Canadians—a far smaller number than the estimated 6 million Canadians annually who experience some kind of mental illness. And the opportunity costs of such provision are the deprivation of people with schizophrenia and bipolar disorder of the specialized diagnostic and pharmacological management skills of psychiatrists.<sup>(12)</sup>

This leaves the pool of providers of counselling, psychotherapy and psychological services who practice outside the publicly funded system. We do not know the exact extent to which there are qualified providers who are currently under-utilized in the private sector and who would therefore be available to provide services should the requisite public funding become available to pay for them. However, it is reasonable to assume that there is some degree of unused capacity amongst qualified providers.<sup>(7)</sup> As one key informant noted:

We can expand the number of practitioners easily. There are vast numbers of counselling therapists, for instance, who are available and are practicing, and could easily be of assistance in diminishing the wait times that are currently being experienced across the nation.

In recent years there have also been many initiatives to better integrate the delivery of mental health treatment in general and of psychological services in particular into primary health care settings, often characterized as collaborative care. As defined by the Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada (CFPC),

Collaborative care is care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support. As in any effective partnership, common goals, clear and equitable decision making, and open and regular communication are key.<sup>(14)</sup>

According to the CPA/CFPC there is no single collaborative model or style of practice. Any activity that enables mental health and addictions and primary care providers to work together more effectively to improve the care they deliver can be collaborative. Collaborative care approaches tend to take advantage of the wider shift to group-based practices in primary care and have been shown to use resources more efficiently, improve access and results as well as satisfaction with care.<sup>(17)</sup> It is worth noting, however, that there is evidence to suggest that collaborative care interventions delivered by multidisciplinary teams do more to improve clinical outcomes for those with persistent or recurrent mental health difficulties than they do for those with the most prevalent psychological problems.<sup>(22)</sup>

It has also proven difficult to incorporate the full range of providers into group-based practices. For example, Family Health Teams (FHT) in Ontario have had some success in increasing access to mental health services but these are generally rendered by counselors or social workers. Psychologists have been incorporated into only a few FHTs and their Quebec equivalents, the Family Medicine Groups.<sup>(19)</sup> As well, group practices that rely on capitation models to pay physicians tend to be more expensive than traditional fee for service models, leading some governments, notably Ontario, to curtail their expansion.<sup>(2)</sup> Less integrated approaches that rely on physician referrals to mental health providers also face challenges related to the affordability of services. When family doctors were asked in 2008 why they did not make more referrals to therapy, the main reason they gave was concern over people's ability to pay.<sup>(1)</sup>

In short, while collaborative care models have much to recommend them, they will require greater funding than they currently have if they are to contribute to expanding access to counselling, psychotherapy and psychological services. Strategies to expand access through community-based mental health services face a similar constraint. Funding would be needed to pay any additional providers of counselling, psychotherapy and psychological services within the community mental health sector.

In summary,

1. It is difficult to see how the unmet need for counselling, psychotherapy and psychological services could be fully met through:
  - expansion of private employment-based insurance plans;

- greater provision by physicians; or
  - encouraging wider implementation of collaborative care or stepped care initiatives in the absence of additional funding
2. Qualified providers who currently practice outside the publicly funded system are a potential resource for meeting unmet need.

## Options for increasing access to counselling, psychotherapy and psychological services

The previous sections point to the conclusion that the primary obstacle to overcome is the absence of dedicated public funding for counselling, psychotherapy and psychological services. In other words, what is required is an initiative that will increase access to counselling, psychotherapy and psychological services for mental health problems and illnesses by making more public funding available to regulated providers who are capable of providing them.

Resolving the funding issue will not automatically resolve all the issues described in the preceding sections. For example, any plan that seeks to increase access to counselling, psychotherapy and psychological services for mental health problems and illnesses using public funds will still have to address the issues of regulation and certification of the providers delivering them. There is a good case, however, for believing that it is a necessary first step which will in itself increase access while also creating more favourable conditions for overcoming the other barriers to expansion.

There are two possible strategies for applying public resources to achieve greater access to counselling, psychotherapy and psychological services:

1. One could 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); or
2. One could create a public insurance plan that would allow privately employed providers of counselling, psychotherapy and psychological services to bill government for their services.

We can call the first the “Grant Funding” model (*GF*) and the second the “Insurance Funding” model (*IF*). Figure 2 illustrates the funding flow characteristic of each of these models.

*GF* entails the funder (government) providing funding to an institution, a service organization or a group of providers in order to enable them to hire certain types of providers to deliver particular programs. The entity that receives the grant is the agent that pays the providers, whether they are engaged on a full-time, part-time or contract basis.

Provider remuneration under *IF* happens through a billing system. An authorized group of providers is able to claim payment for each service they perform at an agreed upon rate. In a public system the provider bills the government.

Both models currently operate within the publicly funded health care system in Canada, and are, in fact, the joint cornerstones of our publicly funded health care system. Roughly speaking, non-medical staff

employed in hospitals are reimbursed using the *GF* model. Hospitals receive grants from government and employ a variety of providers and other staff to deliver care (the hospital in this case is the “gatekeeper”<sup>5</sup>). The *GF* model is also used to fund community-based mental health services and school-based mental health services. Fee-for-service (FFS) payment to physicians, which entails self-employed physicians billing government plans for the cost of their services,<sup>6</sup> is the prototype for the *IF* approach.

FIGURE 2

*Grant Funding (GF)*



*Insurance Funding (IF)*



Both models have also been used successfully internationally to expand access to psychological services. The British Improving Access to Psychological Therapies (IAPT) program is a *GF* plan while the Australian Better Access program is an *IF* scheme. [See sidebars] In both cases, a significant government investment was used to implement a plan that enabled access to counselling, psychotherapy and psychological services to be provided to hundreds of thousands of people. In both countries, the argument was made that the cost to government for expanding access to counselling, psychotherapy and psychological services would be recouped through lower costs for government services elsewhere (e.g., hospital emergency departments, the justice and corrections systems) and fewer benefits needing to be paid out to support people unable to work because of persistent mental health problems.

International experience, on its own, cannot tell us which approach is best for Canada. It does, however, provide us with a strong indication that it should be possible to design an effective plan for expanding access to counselling, psychotherapy and psychological services that is tailored to Canadian reality.

<sup>5</sup> Note that in the diagram the term “gatekeeper” is meant as a generic term for any person or corporate entity that acts as intermediary between the funder and the provider. Thus, a family physician who refers a person to a mental health provider is a gatekeeper, as is a family health team that employs a provider to deliver a publicly insured service. In the diagram a “gatekeeper” regulates access to the provider in the *IF* model, while in Canadian Medicare there is no gatekeeper to regulate access to family physicians. This simply illustrates the fact that a gatekeeper is optional in the insurance funding approach.

<sup>6</sup> At the same time, many physicians are also remunerated using *GF*, being paid a fixed salary for their services while others are paid using different types of capitation model. Under capitation, instead of being remunerated for each intervention, physicians are paid according to the number of people enrolled in their practice.



### **AUSTRALIA**

Since 2006, Australia has had in place a combination of public insurance schemes\* that enable people to receive psychotherapy from a variety of providers: general practitioners, consulting psychiatrists, private practice psychologists, occupational therapists and social workers. Two types of services are covered: psychological therapy and a second group of services, known as focused psychological strategies. These latter services include: cognitive behavioural therapy; relaxation strategies; skills training; interpersonal therapy; and narrative therapy (for Aboriginal and Torres Strait Islander people). Only clinical psychologists may be reimbursed for psychological therapy while other registered psychologists, occupational therapists and social workers can be reimbursed for the focused psychological strategies. General practitioners act as gatekeeper and must provide a referral for patients to have access to either type of service.

\* The two programs that together ensure this access are: Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access) and Access to Allied Psychological Services (ATAPS).

### *The IF approach*

In Canada, as has already been noted, many employers offer private group insurance plans that cover many counselling, psychotherapy and psychological services for their employees. One approach to implementing a public insurance plan that would increase access to these treatments and supports would be to replace all existing private insurance plans with a single public one. A second approach would be to design a public plan that complemented existing private insurance plans by providing coverage to some or all people who are not already covered.

Replacing all existing private insurance plans with public ones would be a costly and disruptive undertaking, which is also highly unlikely to materialize. However, it would be feasible to offer complementary public insurance to people who do not have access to a private plan. A complementary plan could be designed to cover everyone (meaning that, in combination with private insurance plans, it would ensure universal coverage) or it could be targeted to specific segments of the population (e.g., children and youth or veterans).

There are examples of both kinds of insurance programs in Canada. An example of a complementary insurance plan that is integrated with private insurance plans in order to provide universal coverage is Quebec's

pharmacare plan. People who do not have access to a private insurance plan for prescription drug coverage must enroll in the public plan, which caps the amount anyone has to pay for prescription drugs. An example of a complementary insurance plan that is targeted to a specific segment of the population is the Non-Insured Health Benefits plan that the federal government funds for First Nations and Inuit. It provides coverage to those populations for services that are not included under provincial or territorial public health insurance regimes.

An illustrative structure for a public insurance plan to complement existing work-based private insurance for counselling, psychotherapy and psychological services for mental health problems and illnesses is given in Appendix III. An insurance plan of this kind would require the identification of categories of provider, or specific types of services, that would be eligible for reimbursement by the government and the development of an appropriate billing system. The sample plan could be implemented either to cover everyone or be directed at a specific segment of the population.



### **UNITED KINGDOM**

The UK's IAPT program engineered a staged expansion of access which entailed the training of thousands of additional therapists in specific types of psychological counselling. It offers a stepped approach with "lower intensity" therapy provided by therapists trained to deliver a limited number of sessions of CBT (or a few alternate approaches) and more challenging or complex cases referred up to more highly trained therapists such as clinical psychologists. The program is largely delivered through the existing structures of the NHS by practitioners who are usually salaried employees of the NHS.

### *The GF approach*

There are also many possible ways to increase access to counselling, psychotherapy and psychological services using the *GF* model. A *GF* plan to increase access to counselling, psychotherapy and psychological services would entail expanding in some fashion public funding programs that are already in place. In many provinces inter-disciplinary primary health care teams incorporate providers who are able to deliver counselling, psychotherapy and psychological services. A *GF* approach could create more mental health positions in these practices, in hospitals or in community mental health services.

Funding could be directed at specific segments of the population (as with the *IF* approach) such as youth or veterans. It could also be targeted at specific mental health problems or illnesses, or to make certain types of treatments more available. This is what the British IAPT program has successfully done, and a version of it could no doubt be adapted to the Canadian context.

The defining features of the British IAPT program are<sup>(22, 9)</sup>:

- A stepped care approach to the delivery of a limited number of evidence-based treatment modalities (CBT, etc.)
- Delivery of the service by salaried therapists working within the publicly funded system (NHS)
- A coordinated program to train the additional therapists needed to implement the program

As noted earlier, the architects of the IAPT program stressed that it would pay for itself by saving the government money in other areas. Notably, it would enable people to return to work more quickly thereby saving government money on disability benefits, as well as on reduced hospital admissions and other services. Because of the centralized and unified nature of the British system, the same government that makes the expenditures related to the program also reaps the economic benefits it generates. Similarly, the unified structure of the NHS has meant that a single government was able to develop training programs for new therapists that it married with a coordinated effort to implement the program across the country.

In Canada, the deployment of such a structured program would be more complicated because health care delivery is organized and funded by the provinces and territories (with financial contributions from the federal government). One key informant echoed this concern:

I'm not sure that IAPT is a good program for Canada. Because it rolled out in such a way that there was sort of a separate sort of program that is very centrally run, and that's not how our system works in Canada. There's not going to be a national Pan-Canadian sort of clearing house for psychological services. It's not going to function that way.

It is thus likely that any national *GF* program would need to allow for each province or territory to adapt it to its particular circumstances. There are of course, many examples of “asymmetrical” federalism of this kind, and a national program to increase access to counselling, psychotherapy and psychological services would add one more to the list. A second key informant suggested that with such a flexible approach it might be possible to implement the IAPT model in the Canadian context:

What we're saying to the government is the federal government could fund something like this, but it could be implemented in a flexible way. If Ontario really cared about children and youth, it could develop IAPTs for children and youth, and if Nova Scotia was really interested in seniors, it could develop programs for seniors. And these are scalable... So I think there's a way to implement it in a way that's flexible to the jurisdiction ... and their local workforce.

The goal of the UK IAPT model was to increase access to a specific set of treatments delivered using a stepped care approach. However, the application of a *GF* approach is not limited to one type of treatment and it could be used to fund the providers of counselling, psychotherapy and psychological services whether they work in primary health care or community mental health settings.

## Which approach is right for Canada?

Each approach flows public money to the providers of counselling, psychotherapy and psychological services so the choice between them is not a choice between a form of public funding and a form of private funding. Nor does selecting a particular funding model imply that only certain mechanisms for the delivery of counselling, psychotherapy and psychological services can be utilized. For example, either an *IF* or a *GF* approach could be used to enhance the ability of collaborative care practices to increase access to counselling, psychotherapy and psychological services. To do this, an *IF* approach would enable these practices to network with a range of providers who would be covered either by public or private insurance. The “gatekeeper” could refer people to these providers secure in the knowledge that these services would be affordable. For its part, a *GF* approach would provide additional funding directly to the practice to be able to hire or contract with providers of counselling, psychotherapy and psychological services.

*Table 2* summarizes the strengths and weaknesses of each approach.

Both models have their champions in Canada. The “Collectif pour l'accès à la psychothérapie” (Coalition for Access to Psychotherapy) in Quebec has recommended to the government of that province that it adopt an *IF* model, while the Canadian Psychological Association has encouraged governments to embrace either a *GF* approach by developing a Canadian version of the IAPT program from the UK, or adopt an *IF* approach through funding psychological services in primary care settings.<sup>(4a)</sup>

A few studies have estimated the approximate costs for programs to increase access to counselling, psychotherapy and psychological services. The Coalition for Access to Psychotherapy estimated it would cost approximately \$200 million per annum to insure all Quebecers who do not have private group insurance plans so that they can have access to a maximum of six sessions of clinical therapy.<sup>(6)</sup> Extrapolating to the entire Canadian population and increasing the number of sessions to eight would mean a cost of between \$800 million - \$1 billion per annum. A paper commissioned by the Canadian

Psychological Association estimated the cost of implementing a Canadian version of IAPT, which would allow up to 20 sessions for persons that do not respond to low intensity treatment, at \$950 million.<sup>(22)</sup> A different economic analysis estimated the cost of covering the unmet psychotherapy needs of Canadians at \$1.24 billion per year.<sup>(26)</sup>

TABLE 2

	Strengths	Weaknesses
<i>Insurance Funding (IF) Model</i>	<ul style="list-style-type: none"> <li>• Could provide universal coverage, yet also possible to target specific populations</li> <li>• Could provide access to a wide range of providers</li> <li>• Builds on existing private insurance system</li> <li>• Providers practice in most communities</li> <li>• Could be a uniform pan-Canadian program</li> <li>• Could be administered by one or more levels of government</li> <li>• Very difficult for the funder to cancel the program once it is up and running</li> </ul>	<ul style="list-style-type: none"> <li>• Can be difficult for government to constrain costs</li> <li>• Could require changes to regulatory and certification regimes</li> <li>• Will likely require specific mechanisms to encourage the coordination and integration of services</li> <li>• Requires negotiations on fee rates between professional organizations and funders</li> <li>• Will likely require regulation of private insurance and negotiations with private insurers to ensure complementarity</li> </ul>
<i>Grant Funding (GF) Model</i>	<ul style="list-style-type: none"> <li>• Could be integrated with existing primary health care and community mental health care services</li> <li>• Can be used with a wide range of providers</li> <li>• Can be structured to provided stepped care</li> <li>• Can target specific populations</li> <li>• Allows flexible application in different jurisdictions</li> <li>• Costs can be predicted</li> </ul>	<ul style="list-style-type: none"> <li>• Could require training new categories of provider</li> <li>• Must function at close to capacity in order to provide value for money</li> <li>• Services can be scaled back by funders facing fiscal constraints</li> <li>• Requires a structured entity or practice to employ or contract with providers</li> </ul>

It is unlikely that governments will find sufficient resources in the near term to fully address the unmet need for counselling, psychotherapy and psychological services, so choices will have to be made, although it may not be necessary to make the same choice in every region of the country. While there is probably a good case to be made that there would be economies of scale if a single *IF* model was deployed across the country, such a model could also be implemented in a limited number of jurisdictions, (along the lines of what Quebec has done with its pharmacare plan). The *GF* approach, as was noted in the previous section, can easily be adapted to the many different circumstances across the country.

Expanding public funding itself faces challenges. Fiscally constrained governments fear the creation of new programs whose exact cost they cannot entirely predict and that may strain their resources in unsustainable ways. In Canada, there are also obstacles created by the constitutional division of powers which give the provinces and territories the main responsibility for organizing and delivering health care services to the general population. As we have seen in recent Health Accord discussions, provinces and territories worry about the sustainability of federal contributions to health care initiatives and want to make sure that new investments align with the priorities they have established for their jurisdiction.

In assessing which of the two models is better suited to the current Canadian context it will be important to consider which option:

- is more affordable
- is easier to sustain over time
- is better able to respond to priority needs
- provides the best value for money
- provides the greatest number of people with access to counselling, psychotherapy and psychological services
- is more politically feasible in the Canadian context
- would be quicker to implement

As noted earlier, deciding on whether to adopt a *GF* or an *IF* model to flow public funding is far from the only decision that will need to be made in order to develop a clear plan for increasing access to counselling, psychotherapy and psychological services. The subsequent decisions include the following:

1. Should the plan apply to the entire population or should it, initially at least, be targeted at a particular population or populations? What would the criteria be for selecting a target population: addressing the widest possible need, the most intense/immediate need; or removing financial barriers for some populations in order to reduce inequities; or intervening as early in life as possible?
2. Should the plan be a uniform national plan or should it allow for regional or provincial variations?
3. Which levels of government should contribute to the funding of the plan?
4. Should users of publicly funded counselling, psychotherapy and psychological services be required to cover a portion of the costs, or should the plan provide first dollar coverage?
5. What accountability mechanisms should be put in place to track the use of public dollars and measure health outcomes?

## Conclusion

It is possible that the current F/P/T negotiations over a new Health Accord will yield new funding to address unmet mental health needs in Canada. We have seen that such an investment is advisable both in order to improve health outcomes for tens of thousands of Canadians and to generate economic benefits for the entire country.

There are feasible options to achieve this objective that have been proven to work internationally and are consistent with the way in which public funding for health care in Canada has operated for decades. It is not too late for the stakeholder community to offer concrete proposals to all levels of government so that what is universally recognized as a good idea can be put into practice across the country.

## Appendix I

### Overview of providers of counselling, psychotherapy and psychological services

Title	Type of service	Training	Service setting	Regulated
Psychiatrist	Psychiatry is the medical specialty that deals with the diseases of the mind. Psychiatrists use a combination of biological, psychological and social treatment modalities.	Psychiatrists are medical doctors who have received specialized training in diagnosis and treatment of mental health conditions	Most psychiatrists work in multiple settings including: general hospital, community outpatient clinics, specialized psychiatric hospitals, and community office practices. Thirty two per cent of psychiatrists are in private practice.	Royal college of Physicians and Surgeons.
Family physician	In Canada, 89 per cent of family physicians carry out psychotherapy or counseling and 83 per cent offer mental health assessment and prescribe drugs for mental health difficulties	Medical School.	Individual or group practice.	Provincially legislated bodies, known as 'colleges', regulate physicians.
Psychologist	Psychologists help people solve problems with mood, behaviour or relationships. They assess, diagnose and treat mental health difficulties for children, adults, couples, and families who present with cognitive, emotional and behavioural challenges. They may use therapies such as cognitive behaviour therapy (CBT) or other behavioural therapies.	In some jurisdictions, the doctorate degree is required for qualification to practice as a psychologist and in others it is the master's degree.	Some psychologists work primarily as researchers while others work primarily as practitioners in hospitals, schools, clinics, correctional facilities, employee assistance programs and private offices. Many are active in both research and practice. Private practice psychologists, on average, accounted for 40% of licensed psychologists.	Licensure to practice is granted by regulatory bodies in each Canadian jurisdiction.
Psychotherapist	The Quebec Statute (2012) that regulates psychotherapy defines psychotherapy as "psychological treatment for a mental disorder, for behavioral disturbances or for any other problem causing suffering or psychological distress which aims to promote significant changes in the	Special training is required in order to become a psychotherapist. Since 2012 in Quebec, only physicians, psychologists and health professionals licensed as a psychotherapist can practice psychotherapy. In 2015, Ontario brought into effect a 2007 psychotherapy act that	Various.	Only in Quebec, Ontario and Nova Scotia.



Title	Type of service	Training	Service setting	Regulated
	client's cognitive, emotional or behavioral functioning, interpersonal system, personality or state of health."	requires anyone calling themselves a "psychotherapist" to be registered with a new provincial college		
Counsellors	There does not appear to be a single, over-arching or widely accepted definition of counselling, at least not as a health profession. Counsellors refer to themselves by a number of titles or provide services to the public in different of forums, ranging from addictions through to pastoral counselling. Some counsellors focus on specific populations (e.g. youth, elderly, couples, families), while others focus on specific types of counselling therapies (e.g. art therapy, music therapy, psychotherapy or marriage and family therapy).	The most common entry standard for being registered a counsellor (regulated or non-regulated) is a master's degree in counselling or a related field.	Various.	Certification available in some provinces.
Child and youth counsellor	Child and Youth Counsellors perform various services to help children, adolescents, and young adults, such as assessing maladaptive behaviour patterns and socio-emotional functioning in children, adolescents, and young adults.	In Ontario, most Child and Youth Counsellors have a college diploma, with about 1500 hours of field work. Many have degrees in Child and Youth Care with an undergraduate degree in related fields (psychology, sociology, social work, family studies, etc.).	Various.	Certification available in some provinces.
Family therapist	A marriage, couple or family therapist specializes in helping to resolve problems in couple or family relationships. Unlike traditional therapy where the therapist just meets with the individual, family counsellors and therapists usually meet with the individual and one or more family members.	To become a registered couple and family therapist, both a Master's Degree and clinical experience and supervision are required. Marriage, couple and family therapy can be given by any professional that has sufficient training, which usually tends to be social workers, psychologists or psychiatrists.	Various.	Certification available in some provinces.
Nurse	The nursing profession consists of four regulated nursing groups: registered nurses (RNs), nurse practitioners (NPs), licensed practical nurses and registered psychiatric nurses. Usually nurses work alongside other mental health	Independent psychiatric nursing practice can include crisis consultation and intervention; individual, family and group counselling; or psychotherapy.	Nurses may work in many settings including hospitals, addiction and substance use programs, assertive community treatment programs, community health centres, health teams, rehabilitation programs as well as schools.	Provincial and Territorial regulatory bodies.

Title	Type of service	Training	Service setting	Regulated
	professionals such as psychiatrists, psychologists, social workers and allied health professionals such as occupational health. At the same time independent practice is a legitimate practice option for Registered Psychiatric Nurses.			
Social Worker	Social workers help people to deal with problems in their personal, family or work life. They provide counselling or therapy, or help people find necessary resources. Social workers in mental health deliver direct services to individuals, couples, families and groups in the form of counselling, crisis intervention, therapy, advocacy, coordination of resources, etc.	In most jurisdictions in Canada, social workers in mental health have a minimum of a Bachelor of Social Work degree and are registered with a provincial/territorial body that holds them accountable for competent and ethical practice. A Master's degree is often required.	Social workers can work in many settings, including family services agencies, children's aid agencies, hospitals, and schools. Many social workers also work in private practice.	Provincial or Territorial professional body.
Occupational Therapist	Occupational therapists (OT) help people function in school or work through learning skills, or by adapting their work or school environment. OTs can assist with mental health by teaching sensory processing and self-regulation strategies.	All entry-level university education programs for occupational therapists in Canada currently grant a Master's level credential. Since 2008, all university education programs for occupational therapists must lead to a Master's credential to be eligible for accreditation by CAOT.	Occupational therapists are generally employed in community agencies, health care organizations such as hospitals, chronic care facilities, rehabilitation centres and clinics, schools; social agencies industry or are self-employed.	Canadian Association of Occupational Therapists.
Peer support worker	Peer support is a supportive relationship between people who have a lived experience in common. Research indicates that peer support can help a person gain control over their symptoms, reduce hospitalization, offer social support and improve quality of life. It can also benefit family members as they discern the right path for themselves in relation to their loved one.	The various types or formats of peer support are often described as falling along a spectrum ranging from informal support among acquaintances through to formal peer support within a structured organizational setting. There are several organizations that provide training for peer supporters.	Peer support can be provided in both group and one-to-one relationships, and can take place in community groups, clinical settings, and workplaces.	There are several organizations that provide certification of peer support workers.
Elder / Traditional healer	Aboriginal elders, traditional healers and teachers help people using traditional healing practices, which existed prior to Western medical practices. There are		The community.	No



Title	Type of service	Training	Service setting	Regulated
	many forms of healing. Some healers work with plants and medicines, some may counsel, and some use ceremonies such as the sweat lodge.			

## Appendix II

### Washington State Institute for Public Policy Benefit-Cost Results, Selected Programs (2016)<sup>(27)</sup>

Program name (click on the program name for more detail)	Date of last literature review	Total benefits	Taxpayer benefits	Non-taxpayer benefits	Costs	Benefits minus costs (net present value)	Benefit to cost ratio	Chance benefits will exceed costs
<b>Anxiety</b>								
<a href="#">Cognitive behavioral therapy (CBT) for adult anxiety</a> <b>NEW</b>	Sep. 2016	\$31,908	\$10,081	\$21,827	(\$568)	<b>\$31,340</b>	\$56.22	<b>100 %</b>
<a href="#">Acceptance and Commitment Therapy for adult anxiety</a> <b>NEW</b>	Sep. 2016	\$21,738	\$6,875	\$14,864	(\$428)	<b>\$21,310</b>	\$50.78	<b>84 %</b>
<a href="#">Collaborative primary care for anxiety</a>	May. 2014	\$19,461	\$6,223	\$13,237	(\$813)	<b>\$18,648</b>	\$23.95	<b>98 %</b>
<b>Depression</b>								
<a href="#">Cognitive behavioral therapy (CBT) for adult depression</a> <b>NEW</b>	Sep. 2016	\$25,110	\$7,858	\$17,252	(\$500)	<b>\$24,610</b>	\$50.22	<b>100 %</b>
<a href="#">Collaborative primary care for depression</a>	May. 2014	\$7,304	\$2,388	\$4,915	(\$812)	<b>\$6,491</b>	\$8.99	<b>100 %</b>
<a href="#">Collaborative primary care for depression with comorbid medical conditions</a>	May. 2014	\$3,632	\$1,255	\$2,377	(\$857)	<b>\$2,775</b>	\$4.24	<b>92 %</b>

## Appendix III

### Description of a complementary insurance plan for Increasing Access to Non-Pharmacological Treatments (IANPT)

**Objective:** To enable all Canadians who need them to have access to appropriate non-pharmacological treatment without incurring undue financial hardship.

**Method:** Create a public fund that provides insurance coverage for non-pharmacological treatment to people who are not already covered by existing private insurance plans.

#### Details:

1. Obligate all privately-funded group insurance plans to provide access to a minimum of eight sessions with a clinical psychologist, or to reimburse a person's equivalent spending on other registered providers.
2. Establish a national list of self-regulating service providers that are allowed to bill insurance plans (both private and public) for their services, and provide all eligible individual providers with a billing number to enable them to claim reimbursement from these plans for the services they deliver.
3. Establish a government fund, the IANPT, to provide each individual who is not covered by a private insurance plan with an account whose value is equal to 80% of the cost of eight sessions with a clinical psychologist
4. A referral from a family physician is required for a person to gain access to their account. Once authorized by a family physician a person may seek assistance from any registered provider and receive compensation from IANPT for up to an amount equivalent to 80% of the cost of eight sessions with a clinical psychologist.
5. A person's account is activated the first time they actually use the services of a registered provider.
6. IANPT will either reimburse each service user for 80% of the cost of the services they purchase from a registered provider or pay this amount directly to the registered provider; the remaining 20% is to be paid by the person receiving the service.\*

\* The plan involves a user co-pay of 20% of the cost of the services provided. This is necessary in order to prevent any downloading from private group insurance schemes. These almost always entail user co-pay provisions and not including one in the public plan could undermine the existing network of private plans.

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