E-Mental Health Services in Canada: Can They Close the Access Gap?

Les services de santé mentale en ligne au Canada peuvent-ils combler les écarts en matière d'accès?

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Abstract

With significant unmet needs for mental healthcare in Canada, there is a growing interest in e-mental health (e-MH) services to meet gaps in access. While the policy window appears to be open, it is unclear how best to implement e-MH services due to health system barriers that create unmet needs in the first place. We explore the financing, organization and delivery of Canadian mental health services and discuss the promise of e-MH services for alleviating access barriers, highlighting increased policy attention during the COVID-19 pandemic. We consider how evidence-based e-MH services have successfully scaled in other publicly funded healthcare systems and note potential issues in the Canadian context.

Résumé

Compte tenu de la quantité de besoins non satisfaits en matière de soins de santé mentale au Canada, on s'intéresse de plus en plus aux services de santé mentale (SSM) en ligne afin de combler les lacunes en matière d'accès. Bien que la fenêtre politique semble ouverte, la façon de mettre en œuvre les SSM en ligne n'est pas claire en raison des obstacles du système de santé, lesquels donnent lieu à des besoins non comblés. Nous explorons le mode de financement, l'organisation et la prestation des SSM au Canada et nous discutons de la promesse des SSM en ligne visant à atténuer les obstacles à l'accès, en soulignant l'attention accrue accordée aux politiques de services de santé pendant la pandémie de COVID-19. Nous examinons comment les SSM en ligne fondés sur les données probantes ont réussi à s'adapter dans d'autres systèmes de soins de santé financés par l'État et nous prenons note des problèmes potentiels dans le contexte canadien.

Introduction

Mental health (MH) disorders are common, affecting up to one in five Canadians annually, causing substantial disability and economic burdens (Lim et al. 2008). Yet almost one-third of Canadians do not receive sufficient MH services to meet their needs (Moroz et al. 2020), facing long wait times and geographic variation in provider supply (Jaakkimainen et al. 2014). Underlying this access gap are the ways in which MH services are funded, organized and delivered. While evidence-based psychological interventions, such as cognitive behavioural therapy (CBT), are first-line treatments for the most prevalent MH disorders, access to these services through Canada's public healthcare system is limited owing to inadequate physician supply and paucity of coverage for non-physician services (Gratzer and Goldbloom 2016). Having been referred to as "the orphan of Medicare," MH services delivered by non-physicians fall outside the *Canada Health Act* (*CHA*) (1985) as the original intention to expand the *CHA* coverage was never fully realized (Romanow 2006: 1).

Discussion

Canada's health coverage is characterized by three layers of services (Martin et al. 2018). Physician care and acute care fall under public services, funded primarily through public taxation and delivered via the universal single-payer systems of the provinces and territories (PTs). Other MH service providers – including psychologists, therapists and social workers – fall under mixed services funded through public taxation, private insurance (primarily through employers) and out-of-pocket payments. Fully private services also include MH providers. In a highly decentralized health system, the exclusion of non-physicians from the *CHA* made the continuum of MH care the responsibility of PTs. PTs typically provide coverage for psychotherapist physicians (psychiatrists and family physicians who offer psychological therapies) but not for other health professionals. While some non-physician services are available in the community through public MH agencies and hospitals,

non-physician services are primarily offered on a fee-for-service basis, covered by personal finances or private health insurance. For the latter, maximum coverages typically equate to approximately only two to eight sessions of therapy (CMHA 2018), while almost 30% of Canadians, predominantly the economically disadvantaged, lack private health insurance altogether (Martin et al. 2018). With MH having been referred to as "the orphan of Medicare" (Romanow 2006: 1), the *CHA*'s focus on physician and hospital-based care restricts the ability of the federal government to hold PTs accountable for MH spending and system performance outside these areas.

Despite many non-physicians being trained in delivering evidence-based psychological interventions to adult populations, individuals with mental illness continue to present to primary care providers, walk-in clinics and emergency departments (Cohen and Peachey 2014). General practitioners are typically the gate keepers for specialty physician services (Dyck 2018). It is estimated that almost 80% of Canadians rely on their family physician for MH care, though 15% report not having a regular healthcare provider (CMHA 2018). While some family physicians provide psychotherapy, Cohen and Peachey (2014) found that most are reluctant to do so, citing concerns around lack of experience. Adding to this complexity is the geographic availability of providers. While rural and northern locations have limited MH services (Moroz et al. 2020), a recent Ontario-based study found that even in high-supply areas, psychiatrists took on fewer new patients compared to low-supply areas (Kurdyak et al. 2014). This suggests that simply increasing physician supply may not suffice to improve access. Cohen and Peachey (2014) argue that physicians should target assessment, diagnosis and care for severe conditions, while middle-range needs should be filled by other appropriately trained providers.

While Canada devotes only about 7% of its public funding to MH (a decline from 11% in the 1980s), some Organisation for Economic Co-operation and Development countries devote as much as 18% (Bartram and Lurie 2017). In 2015, the Canadian government opened a window of opportunity by promising to improve access to MH services, offering $5 billion over 10 years to support PTs. This position had considerable support from professional associations and stakeholder organizations, as well as the public, with 90% of Canadians approving the transfer and 80% prioritizing MH services for a new Health Accord (Tuerk et al. 2018). Nonetheless, jurisdictional issues threatened to undermine meaningful progress (Bartram 2017). Interestingly, a recent modelling study estimated that every $1 invested in medicare coverage of psychological services would yield approximately $2 in societal savings, thus paying for itself (Moroz et al. 2020). However, a 2004 survey of policy elites found that while at least 50% desired full coverage for psychological counselling by physicians, only 30% wished for full non-physician MH coverage (Deber and Gamble 2004). The large proportion of providers opposing such coverage offers important insights. Wiktorowicz et al. (2020) observe path dependency in Canadian MH policy, noting that physicians advocating for hospital-based services – rather than community-based services –

have had a stronger policy influence than allied health professionals due to their direct access to ministries and suggesting that stigma around mental illness resulted in a weak political constituency for people with MH needs.

Given the growing demands, there is an urgent need to utilize cost-effective, sustainable and scalable solutions for delivering care. Technological innovation is a promising approach for alleviating access issues (Moroz et al. 2020). Through a variety of digital modalities (computer, web-based or mobile device applications), e-mental health (e-MH) services include self-management tools and therapist-supported psychological therapies (Lal 2019). Commonly cited strengths include the potential to reach not only individuals living in remote locations but also those in urban settings facing transportation, physical disability or scheduling barriers. Internet-delivered cognitive behavioural therapy (iCBT) is a notable example of an effective intervention for depression and anxiety that can be self-led, therapist-guided or both, with users navigating pre-set text and exercises aimed at modifying maladaptive thinking and behaviour patterns and developing coping skills. Targeted investments in e-MH services, including iCBT, have positively impacted patient access and outcomes in several countries where innovations scaled beyond pilot projects to become permanent services (Titov et al. 2018). Gratzer and Goldbloom (2016) offer the UK and Australia as prime examples of a strong policy push toward innovation, offering important learnings for Canada. Since 2008, the UK has been investing in publicly funded psychological interventions. The Improving Access to Psychological Therapies (IAPT) model (NCCMH 2018) entails stepped care whereby individuals can self-refer, and treatment intensity, expertise and frequency are assigned based on illness severity. With iCBT as one treatment modality, the IAPT model represents a monumental expansion of MH services in the UK, with over 6,000 therapists completing training and over two million people accessing care as of 2015, with high recovery rates leading to increased employment, showcasing both clinical and economic effectiveness (Gratzer and Goldbloom 2016; Titov et al. 2018). Australia has also expanded access to psychological services to address geographic and personal barriers to accessing care. Australia's government added psychologists and other MH providers to public health insurance coverage and implemented multiple iCBT programs within its stepped-care approach, yielding high treatment effectiveness and patient satisfaction (Gratzer and Goldbloom 2016). These substantial federal investments allowed e-MH services to scale and reach a large number of individuals by targeting mild concerns while focusing in-person resources on those requiring more intensive intervention (Lal and Adair 2014).

Along with the recent funding increases, there has been some movement toward e-MH innovation on the Canadian policy agenda. A review of policy documents published between 2011 and 2019 offers important insights into the pre-pandemic era, highlighting that technology had little strategic attention (Lal et al. 2021). Since 2014, the Mental Health Commission of Canada (MHCC) has been promoting evidence-based reviews and environmental scans of e-MH initiatives and has also released an implementation tool kit.

Federal funding for innovation has also increased, including the Canadian Institutes of Health Research's eHealth Innovation Partnership Program and strategic investments in e-MH researchers through the Canada Research Chairs programs. To use Ontario as a local example, in 2017, the province pledged $72.6 million over three years to improve access to psychotherapy for those with mild/moderate anxiety and depression (Vasiliadis et al. 2021). Consultations with Health Quality Ontario culminated in a decision to provide CBT via community-based therapists. Importantly, the online modality, iCBT, was scrutinized in 2019 by a health technology assessment committee that deemed it worthy of public funding (HQO 2019). In March 2020, Ontario announced its plan for improving its MH service continuum using the IAPT stepped-care model (Government of Ontario 2020a). Ontario's investment of $3.8 billion over 10 years included the launch of its Structured Psychotherapy Program, with no out-of-pocket costs for CBT and with two fully funded, self-guided, therapist-supported iCBT programs (Government of Ontario 2020a). Lal et al. (2021) caution, however, that despite these promising advancements, strategic and coordinated leadership is required to scale pilot initiatives. Reliance on e-MH services to bridge the access gap in other countries required substantial investments in the recruitment and training of non-physician staff, highlighting the importance of reaching the goal of spending 9% on MH set by the MHCC for 2022 (Gratzer and Goldbloom 2016).

The COVID-19 pandemic created another window of opportunity for healthcare reforms through the rapid adoption and routinization of digitalization. Wind et al. (2020) assert that COVID-19 was a turning point for e-health since services had to be provided online at a "warm" (p. 1) distance. This entailed increased development and use of e-MH services that reduced scarcity by substitution, such as with self-guided interventions, or by overcoming geographic barriers for therapist-guided e-interventions. Despite two decades of evidence on digital MH services, their implementation in routine care was continuously stalled until the pandemic accelerated adoption by both patients and providers. In May 2020, Prime Minister Justin Trudeau announced an investment of $240.5 million to develop, expand and launch e-MH initiatives (e.g., Wellness Together, which includes virtual access to peer support and professional counselling) to improve access (Government of Canada 2020). Several areas in Canada also responded to the COVID-19 pandemic by delivering e-MH services (e.g., Text4Hope, MindHealthBC, Be SaskWell), but the extent to which these initiatives curb access gaps is unclear. In May 2020, Ontario announced an expansion of iCBT and pledged $12 million to help MH agencies hire and train more staff and improve infrastructure for virtual supports (e.g., BounceBack) (Government of Ontario 2020b). While this overview focuses on e-MH services for adults, many innovations have also been developed specifically for children and youth (e.g., Kids Help Phone, Integrated Youth Services).

With fleeting policy windows, swift action is paramount, particularly since pandemic-related funding may not be sustained long term. Moroz et al. (2020), therefore, recommended that policy makers allocate funding support for scaling up service delivery. Considering the interest in and use of technology during the COVID-19 pandemic,

Torous et al. (2020) argue that increased investments in the present will yield unprecedented access to high-quality e-MH services in the future. Ironically, the same system-level barriers that create unmet MH needs in the first place (limited physician capacity and scarce public coverage for non-physician providers) are the ones that may limit the ability of e-MH services to scale, sustain and tackle the access gap. Provider availability and capacity to use e-MH services are often unaddressed assumptions in existing literature (Tuerk et al. 2018). With the promise of overcoming geographic, scheduling- and stigma-related barriers to care, potentially widening the pool of patients utilizing e-MH services, if capacity is not increased (via hiring and/or training more therapists), unmet needs will remain. A recent *Canadian Medical Association Journal* news release (Vogel 2019) argued that "[v]irtual care can't fix physician shortages underlying access woes." Since e-MH services will not bridge access gaps without enough workers manning them, human resources remain a critical concern for policy makers.

Ontario's pandemic response further illustrates the importance of integrating non-physician MH providers into public health insurance. Scharf and Oinonen (2020) state that Ontario's physician-centric response, relying on publicly covered providers through enhanced billing codes is problematic, since overworked physicians who are typically not trained to provide psychotherapy are being pressured and incentivized to provide potentially suboptimal care. Gratzer (2020) suggests that even an enhanced complement of physicians would not suffice to close the gap. By failing to increase public access to non-physicians who can provide both effective and cost-effective care, the physician-centric approach puts patients at risk while increasing stress on the already overburdened providers. Other countries have successfully expanded coverage to psychologists and other licensed therapists. Ontario's IAPT–inspired Structured Psychotherapy Program is showing promise for e-MH scale up, illustrating that evidence-based treatment can be successfully delivered by non-physicians both in terms of effectiveness (achieving outcomes equivalent to services delivered by physicians [Stanley et al. 2014]), and efficiency (such as cost savings). iCBT further overcomes geographic access barriers and can be delivered asynchronously, with self-guided modalities reducing therapist time and associated costs. Nevertheless, Torous et al. (2020) remark on the importance of investing in not only hiring and training e-MH providers but also in ensuring that all patients have the digital literacy and competency to partake in services. When capitalizing on the COVID-19 pandemic as a window of opportunity for expanding access to services through e-MH care, digital equity must remain at the forefront (Rich et al. 2019), with additional considerations around risk mitigation (Stevens et al. 2021)

Conclusion

The system-level barriers underpinning Canada's unmet MH needs, including the scant coverage for non-physician services under the *CHA* and the limited availability and capacity of psychiatrists and primary care providers to deliver effective psychotherapy, have not been resolved despite recent funding increases. With the COVID-19 pandemic opening a policy window, the promise of e-MH services for efficiently overcoming geographic and

personal access barriers is at the forefront. However, e-MH services are not a panacea. If the system-level factors underlying Canada's pervasive access issues are not addressed, it remains uncertain whether e-MH services can close the gap. A system-level, creative expansion of the publicly funded MH workforce that includes non-physician providers is warranted in order to close the access gap and meet the growing demand for MH services.

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