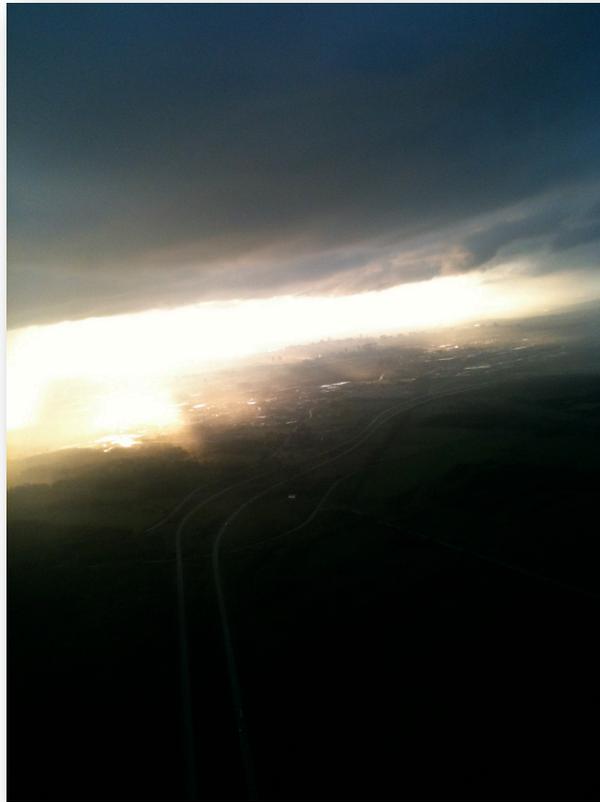


AN IMPERATIVE FOR CHANGE
ACCESS TO PSYCHOLOGICAL SERVICES FOR CANADA



A REPORT TO THE CANADIAN PSYCHOLOGICAL ASSOCIATION

March 2013

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Acknowledgements

This study was undertaken with the support and guidance of the Senior Management of the Canadian Psychological Association (CPA). This enabled many essential components of the study to be addressed efficiently, providing substantial benefit to the work of the consultants. At the same time, the CPA stressed, throughout, the autonomy of the consultants and the importance of an assessment that is independent of the CPA. This principle underpinned the approach to the study mandate and its conduct.

Many individuals contributed to our understanding of the issues and challenges, including history and fiscal realities. These individuals were independent and knowledgeable resources, organizational and agency representatives, and federal, provincial, and territorial ministry and departmental staff, all dedicated to finding solutions to the dilemma of ensuring timely access to mental health services for those in need. As well, there were valuable contributions from the private sector and, for this too, we are grateful, particularly as the sharing of perspectives and funding approaches by this sector carries specific challenges. Further, the survey assistance provided by the Association of Canadian Academic Healthcare Organizations provided valuable insights.

While the benefit from the input of numerous knowledgeable resources was substantial, responsibility for the acquisition, collation, and interpretation of the qualitative and quantitative data was that of the consultants, alone, and should not be attributed elsewhere.

I Introduction

The Canadian Psychological Association is seeking an independent assessment of access to mental health and psychologists' services for Canadians; currently, the state of coverage of these services tends to be fragmented, at best, and, frequently, non-existent.

Fulfilling the mandate, scope, and deliverables of this project requires convergence of qualitative and quantitative research as the underpinning of analyses and the understanding of access and funding issues, including the development of models of care and their economic analyses. This is achievable through attention to the key requirements of the study:

- Understanding of the complexities and interactions within Canadian health care systems
- Understanding of health funding and governance issues
- Understanding of health human resources
- Detailed literature search and analyses
- Health economics and costing models
- Acquisition and collation of qualitative research incorporated into an analytic framework
- Acquisition and collation of health care data and subsequent analyses

The agreed deliverables for this report are, as follows:

- i. Analysis and abstraction of relevant literature that draws upon national and international evidence
- ii. Environmental scan of provincial and territorial government policies and, where applicable, services within jurisdictions, such as local or regional addiction counseling
- iii. Incorporation of trends in federal funding and private coverage of psychologists' services
- iv. Review of existing quantitative analyses of the direct and indirect benefits of enhanced funding of services provided by psychologists
- v. Cost projections for at least two models of enhanced access to psychological services

A mapping of some of the relationships between psychologists and other professional groups is included to clarify issues that will affect the potential for collaboration in current and potential models of mental health care. This activity included discussions with representatives of other professional groups about their views on the role of psychologists.

This report incorporates the results of the literature reviews, evaluations of models, and recommendations for next steps. It articulates the business case for implementing the preferred model(s). Other topics include a rationale and recommendations to improve, where possible, access through employee workplace benefit plans and employee insurance. Contextual discussions of the

issues around aboriginal mental health and mental health issues for elderly populations are included. These population cohorts were addressed, separately, not to stress their issues, but because other cohorts, such as children/youth and corrections, were included as specific areas of the environmental scan.

II Executive Summary

The delivery of mental health services in Canada can be characterized as a silent crisis. An increasing demand and need is unmet by provincial and territorial health care systems and private insurers. Instead, attention has continued to focus on politically sensitive areas, such as cardiovascular interventions and joint replacement surgery. Nonetheless, a mental health disorder affects one in five Canadians with an annual societal cost of \$50 billion, as reported by the Mental Health Commission of Canada.

Historically, mental health care often resulted in institutional care; the trend back to community care and diminishing stigmatization has not been matched with appropriate community level support.

The discipline of family medicine in Canada is faced with the challenges of prevalent mental health disorders and inaccessible consulting services. Family physicians, not infrequently, are stymied by the inability to access mental health services, whether as an insured or uninsured service. Their patients are denied required and appropriate care. Despite an awareness of the benefits of evidence-based psychological interventions, there continues to be a severe gap in the ability of patients to receive needed care. Many physicians have been left with the inappropriate referral of patients to emergency departments and with unsatisfactory outcomes.

The imperative to address mental health issues has long been recognized in health policy development. Two major reports were produced in 2002 with a view to setting criteria for the future of publicly financed health care in Canada. A report from The Standing Senate Committee on Social Affairs, Science and Technology (the Kirby Report) recommended enhanced funding for provinces to establish multi-disciplinary primary care groups, with the provision that services should be delivered by the most appropriately qualified health care professional.

The report of the Commission on the Future of Health Care in Canada (Romanow Report) recommended targeted funds for five priority areas, including primary care and home care. Estimates of the annual costs of new home care programs were \$970 million; of which \$568 million would be for home mental health management. The Kirby Commission scheduled a report on mental health as part of the future work arising from its deliberations, which was completed by a Senate Standing Committee in 2006. Following that report, the federal government established the Mental Health Commission of Canada.

A number of initiatives have been undertaken by mental health stakeholders. These included the following:

- i. The Canadian Collaborative Mental Health Initiative (CCMHI) was developed in 2003 by a consortium of twelve national organizations. Health professionals' organizations participating in CCMHI consisted of physicians (family physicians and psychiatrists), mental health nurses, psychologists, occupational therapists and pharmacists.

- ii. The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) was formed in 2004 by ten stakeholder organizations to develop a framework and process to implement primary care models featuring greater collaboration among professionals.
- iii. The Mental Health Table Access Forum was formed in 2009 by a number of associations representing health care providers active in mental health. The purpose of the Table is to provide a venue for member organizations to share information and to discuss issues relevant to advancing mental health and mental health care in Canada.
- iv. Integrating Needs for Mental Wellbeing into Human Resource Planning (ProjectIN4M) (2010-2011). Project IN4M was planned as a three-phase research project IN4M's overall goal is to improve accessibility to high-quality mental-health services through needs-based predictive modeling of health, social, education, criminal justice and private sector human resources.

These initiatives have contributed to the framing of mental health issues in Canada, identifying the need for significant changes in service delivery and the way in which society and providers regard mental health. The Mental Health Commission of Canada published a comprehensive health strategy in the spring of 2012. The priorities and key recommendations for access to services are summarized as follows:

- i. Expand the role of primary health care in meeting mental health needs;
- ii. Increase the availability and coordination of mental health services in the community;
- iii. Provide better access to intensive, acute, and highly specialized services, treatments and supports when they are needed;
- iv. Recognize peer support as an essential component of mental health services;
- v. Increase access to housing with supports, and to income, employment, and education support.

Examples of models to improve access to psychological services can be found across Canada. While the models differ in the degree of involvement and role of psychologists, reviews have shown that they improve access to psychological services. These models indicate that there is an increased movement in Canada toward collaborative community-based mental health services. Family physicians that have access to mental health professionals recognize the important contribution that they make as part of the mental health team. A number of the models emphasize the benefits of a greater role for patients and families in the delivery of mental health services.

Models in the United Kingdom, Australia, Netherlands, and Finland provide examples of countries that have provided the regulatory framework and funding to support the increased use of psychologists in mental care. The United Kingdom and Australia have models that rigorous evaluation has shown to be cost-effective.

The United Kingdom has introduced two major initiatives to improve mental health during the last six years. The first, known as Improved Access to Psychological Therapies, is a structured program designed to increase access to cognitive behavioural therapy through the use of psychological therapists trained to deliver CBT within a team approach. The second, known as No Health Without Mental Health, is designed to improve public services for people with mental health problems, with its scope including the underlying causes of mental ill health.

Experience to date with the IAPT program has been positive, with its goal of 50% of persons in treatment progressing to recovery close to realization. Concerns have been identified about issues such as waiting times and choice of therapy or location of service.

Australia introduced a program known as the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative in 2006 as a component of the Council of Australian Governments' national action plan on mental health 2006-2011. Under this program, persons with diagnosed mental health disorders can receive specific insured services from general practitioners, consulting psychiatrists, private practice psychologists, appropriately trained occupational therapists and social workers. The purpose of the Better Access Plan is to improve treatment and management of mental illness within the community. The program also addresses issues in the delivery of mental health care by encouraging collaboration between general practitioners, psychiatrists, psychologists and appropriately trained social workers and occupational therapists.

The characteristics of the UK and Australian programs to provide better access to psychological therapy services are very different in terms of how care is funded and delivered. But they also share common characteristics, which can be seen as factors contributing to the success of such programs, and which can be incorporated in efforts to expand access to psychological therapies in countries with different cultures and systems of health care organization.

- i. The two programs have clear goals for treatment and outcomes.
- ii. Both programs have detailed reporting mechanisms – through the MBS administrative system in Australia and the mental health reporting system in the UK.
- iii. Both programs focus on specific conditions, which consist of mild or intermediate cases of anxiety and depression. The Australia program is also treating a significant number of persons with more severe conditions and government has committed to developing other resources for these clients in future. Programs to deal with severe and long lasting conditions are being developed as part of the expansion of IAPT in the UK.
- iv. Clients of the service are recognized as important in decisions about therapy. The UK mental health programs profess to be guided by the slogan, 'No decisions about me, without me.'
- v. Community groups and stakeholder organizations are recognized in both countries as having key roles in the larger mental health environment. Support mechanisms within

families, communities and workplaces are also seen as key to successful mental health programs.

- vi. Both programs have a clear articulation of the roles of psychological therapy providers. Both have structured levels of service that include highly trained clinical psychologists and allied health providers.
- vii. Both programs incorporate provider training programs, although the UK IAPT program is much more highly structured in this regard.
- viii. Both programs include evaluation criteria. Both programs are included in an annual mental health reporting process.

The MHCC recommended that two percent of present health expenditure in Canada be reallocated to mental health, which would be valued at \$4 billion in 2011. The current cost of mental illness and addiction, based on 2003 studies undertaken for the commission adjusted for inflation, would be in the area of \$60 billion. Approximately 10% of these costs occur in the health care sector while 35% represent the cost of lost productivity and 55% represent the value of lost health. The MHCC report also recommended a reallocation of spending within the mental health envelope with a view to achieving greater effectiveness and efficiency. It is difficult to estimate the economic payoff from these reallocations but it is clear that very large gains could potentially be realized. For example, if these reallocations could reduce the burden of untreated or under-treated mental illness by even one-third, the payoff arguably could be as high as \$20 billion.

The essential elements of a business case are the prospect of a positive return on investment (ROI) and a demonstration that the activities proposed are an appropriate way to achieve the objectives that are being pursued. In the case of improved mental health, there are many activities that have the potential to provide positive benefits. There are also many actors who stand to benefit, most notably the individuals whose mental health can be improved, their communities, employers, government and society at large.

Return on investment in mental health is difficult to measure for a number of reasons, including the facts that (1) benefits often accrue over a longer time span and are harder to quantify than costs, (2) indirect benefits are hard to measure, especially when they occur in different economic sectors (e.g. reductions in costs that occur in the justice system) and (3) factors such as socio-economic conditions and chronic disease can impact the effectiveness of mental health interventions.

Recent analysis of research in the UK found that substantial returns to investment could be achieved in the early detection and treatment of common mental health conditions such as conduct disorder, medically unexplained symptoms, depression at work and psychosis. Benefits were diffused across the public and private sectors.

There is a significant literature that demonstrates the cost effectiveness of psychological services. A comprehensive literature review in 2002 found that:

Psychological interventions can effectively treat a wide range of child and adult health problems, including depression, generalized anxiety disorder, panic disorder, post-traumatic stress disorder, eating disorders, substance abuse, and chronic pain.

There is mounting evidence that there are also effective psychological treatments for diseases and disorders that are routinely seen in primary care medical practices but that are typically difficult to medically manage.

Psychological therapy has been shown to be less expensive than, and at least as effective as, pharmaceutical therapy for a number of common conditions.

Psychological interventions also have the potential to reduce health care costs, as successfully treated patients typically reduce their utilization of other health care services. In some instances, the reduced cost to the health care system may actually be greater than the cost of the psychological service, thus resulting in a total cost offset to the system.

Evidence on cost effectiveness in the European Union show that treatments of depression typically have a cost per QALY gained less than one fifth the threshold usually considered appropriate for cost effectiveness in developed countries.

There has been a general acceptance by provincial governments that there are shortages of physicians in Canada, which has led to a 67% increase in Canadian medical school graduating class size between 2001 and 2011¹. Assuming this to be evidence of governments' determination to provide adequate levels of appropriate care, it is a logical next step to engage more members of other professions to provide care where they are uniquely capable of doing so. This is the case with mental health; psychologists are specifically trained to diagnose and treat the full range of mental disorders. Engaging psychologists to treat or direct treatment of mental disorders provides a better option to patients than the isolated pharmacological management of symptoms. Using psychologists to treat mental conditions also frees up family physicians to concentrate on the diagnosis and treatment of medical conditions.

The MHCC finding that twenty percent of Canadians have mental health problems and that only one-third received care leads to the conclusion that fourteen percent of Canadians require care and are not receiving it. It is necessary to rationalize as well as to increase supply to meet these needs, and the MHCC recommendation for reallocating expenditure recognizes this fact. Effective mental health care is bound to be more cost effective than treatments of symptoms that do not alleviate the underlying mental health condition.

The models reviewed make it clear that collaboration with psychologists offers considerable advantage for patients and physicians. It is also clear that there is no single model that stands out as an exemplar. Rather, there are a variety of models based on local circumstances and the preferences of both physicians and psychologists. Accordingly, we have chosen to outline the key factors that will support models of collaborative care, which can act as a guide for developing new models. These factors are outlined below.

Collaborative Primary Care

Collaborative care models should be managed by group practices and group practices should adopt administrative structures that support collaborative management and shared professional services. Participation in ownership by professionals in the practice, joint decision-making and professional management where the size of practices permits are examples.

Designated funding should be provided by provincial RHA or MOH. This funding should be in the form of capitation or global budgets based on patients served, number of professional FTEs and the range of services provided. The inclusion of psychologists' services in the funding envelope should be seen as a logical progression of the overall transition to more effective and efficient primary care in Canada. Budgets should be managed by the practices, which would have discretion to determine the appropriate ratio of physicians, psychologists and other health professionals to provide optimal care. Staffing guidelines for the mix of professionals should be developed by professional associations (e.g., CPA, College of Family Physicians).

The roles of psychologists should include the following activities:

- Assessment and diagnosis
- Consultation and education with team members
- Program and service development and evaluation
- Treatment delivery for complex, chronic, co-morbid conditions involving mental health

The actual mix of these activities will depend on circumstances and requirements within the collaborative practices. Education and consultation should be a prominent feature of all models to ensure that mental health needs of patients are identified and dealt with as part of the case management process. Where services such as psychotherapy or CBT are required, psychologists will normally be the most qualified team member to either provide or manage care. Decisions on these issues are best made between members of the care team.

Stepped care programs to care for patients with mental health issues should be incorporated in treatment plans. In stepped care, the intensity of psychological interventions typically begins at a low level and progresses to more intensive levels when required. This approach allows many patients to be treated by nurses, social workers or others with appropriate training, under the guidance of a psychologist.

Collaborative models should use electronic health records and appropriate information technology to ensure that all test and treatment results can be shared by team members on a "need to know" basis, in order to share test results, professional insights and to provide the most appropriate care without duplication of effort or unnecessary inconvenience to patients.

Specialist Care

The review of Canadian models found examples of psychologist and physician collaboration in children's care, pain clinics, and in cardiac care.

- i. Specialist collaborative models should be managed through Regional Health Authorities or hospitals.
- ii. Dedicated funding should be provided as part of the budget for the specific specialty service, based on number of FTEs at negotiated rates.
- iii. The roles of psychologists should be focused on diagnosis and co-education, especially where there are medically unexplained circumstances or where the conditions treated predispose patients to anxiety or depression.
- iv. Psychologists can carry out most or all of the responsibilities presently assigned to psychiatrists in psychiatric inpatient or outpatient care. Use of psychologists may be especially attractive for hospitals providing psychiatric services, especially while understaffed.
- v. Collaborative mental health models that include psychiatrists, psychologists, and mental health nurses have the potential to provide cost-effective, stepped services for hospital in-patient and ambulatory care clinics that align with patient needs. Collaborative models should be tested in a number of academic centres, with a view to encouraging the widespread adoption of successful models.

Fee-for-Service Models

Estimates in the Environmental Scan indicated that fee-for-service or contract payments to private practice psychologists in Canada presently are in the area of \$950 million annually. Most of this expenditure is made by clients, insurance firms, or workers compensation boards. Financing of these existing services is clearly an issue in introducing new models. A universal psychologists insurance plan, along the model of physicians fee-for-service, would transfer most present expenditure to government. Access for groups that cannot afford services at present would have to be purchased at additional costs.

There are compelling arguments for providing more support for the cost of fee-for-service psychology through employer insurance, given that lost productivity resulting from mental illness and addiction is estimated to be approximately \$20 billion annually and that employers would benefit directly from recovering these losses. Authoritative estimates suggest that employers could recover approximately \$6 to \$7 billion annually from appropriate programs of prevention, identification and treatment of mental illness.

Insurers also stand to reduce costs of providing disability insurance if employees who need psychological assistance can be treated in a timely manner, preventing time lost for some and reducing the length of disability claims for others. The following measures could be undertaken with a view to increasing insurance coverage for private practice psychology services:

- i. Employers need to be educated in the economic benefits of providing enhanced employee insurance coverage for psychologists services
- ii. Insurers should include psychologists services as a standard benefit in extended health benefit plans, reduce conditions that limit the period of treatment and accept self-referrals for treatment
- iii. Governments should provide incentives for enhanced insurance of mental health care by insisting that firms bidding on substantial government contracts provide employee mental health insurance up to a designated minimum standard
- iv. The federal and provincial governments should show leadership by making modifications to coverage provided under government employee insurance plans to increase coverage and reduce limitations on the amount of benefits per patient
- v. Workers' Compensation Boards should consider increasing coverage with a view to reducing time lost in disability; this enhancement could be supported by premiums for industries where there is a high risk of short and long-term disability through stress and addiction

Models Based on the UK IAPT Experience

The IAPT model is described in the section on *International Models and Access to Psychological Services*. It offers advantages where there is a desire to adopt a comprehensive approach to mental health services and to incorporate training and rationalization of roles in the program. It is considered to be especially effective for the treatment of anxiety and depression. The program was not meant to substitute for existing services, but to provide access to the most appropriate levels of care for persons who are not receiving treatment or assistance at present. Although the UK IAPT model is national in scope, in Canada, provinces could choose to adopt the model and to roll it out incrementally, as was done in the UK. The existence of training programs in the UK and a considerable body of evidence about the most effective means to deliver IAPT will be an advantage when planning implementation. Characteristics that would facilitate adoption of the program to the Canadian context are:

- i. Programs would be managed by RHAs with designated funding from provincial MOH. Training programs would be delivered by universities or community colleges, depending on the intensity of therapy to be provided by students (high intensity or counseling and assistance). On-site training would be an important part of the training programs, allowing for the provision of care on a residential model, while professionals are being trained.

- ii. Delivery sites would be concentrated in existing practice environments, allowing efficiencies in administration, professional collaboration and economies of scale in providing treatment. The following sites could host IAPT programs:
 - Hospital ambulatory care clinics
 - Community mental health centres
 - Large primary care group practices
- iii. Roles of psychologists would include team leaders, supervisors, educators, and high intensity care, primarily in the form of cognitive behavioural therapy
- iv. Roles of other health care providers would include:
 - Social workers, nurse therapists, occupational therapists, and others who complete designated courses - non-intensive therapy and counseling

Recommendations

Following are recommendations derived from the evidence of literature and qualitative and quantitative interpretations of the environmental scans. If accepted, the timing of implementing the recommendations will need to vary, and the diversity of stakeholders, each with unique interests and priorities, will necessitate strategic planning, sensitive to the rate and magnitude of change. That notwithstanding, underpinning the recommendations is clear evidence of resource allocations that require realignment with jurisdictional priorities and the needs of the populations served, and the unique role and value that can be provided by well trained psychologists.

Recommendation 1

That collaborative primary care models that include psychologists be an accepted fact in the evolution of collaborative care in Canada. Administrative structures and funding methods should be modified to recognize the importance of professional and client decision making and to eliminate bureaucratic rigidities. Incentives should be provided for best practices but only for verifiable excellence or innovation in improving patient outcomes.

Recommendation 2

That collaborative specialist care models be implemented in hospitals and other sites offering secondary and tertiary care for conditions where psychological services have been shown to improve patient outcomes, such as cardiac care and pain clinics.

Recommendation 3

That fee-for-service models continue to be the preferred funding method for insurers, social security funds (WCB and publicly funded liability insurance), and for individuals who prefer to use private practice psychologists' services.

Recommendation 4

That a greater share of the cost of private insurance be borne by employers that sponsor individual plans. These employers stand to realize potentially large gains from a reduction of lost time from work and a reduction in disability benefits due to work-related stress.

Recommendation 5

That insurance plans eliminate unnecessary restrictions on mental health services, which often interfere with optimum treatment regimens; and requirements for physician referrals, which pose unnecessary costs for patients and provincial medicare programs.

Recommendation 6

That programs based on the UK IAPT model be recommended to provinces that wish to adopt a comprehensive approach to mental health services. These programs can be managed by RHAs and be coordinated with existing community mental health services.

Recommendation 7

That provinces that wish to establish IAPT programs be encouraged to begin with RHAs that serve populations that are underserved in terms of mental health care. Additionally, the RHAs should have innovative leadership and be able to document and share results with their peers. Additional sites can be added incrementally, gaining from experience by pioneering sites.

Recommendation 8

That financial incentives be provided for IAPT models that excel in terms of innovative approaches and patient outcomes.

Recommendation 9

That CPA and its US counterpart, the APA, set up a liaison process to pool experience and, where possible, join forces to promote the adoption of evidence-based best practices in integrated primary care.

Recommendation 10

That CPA, physician groups, and other mental health stakeholders take the lead in promoting appropriate models of care for mental illness and addiction. The contributions of such models, as a way to improve mental health outcomes and the financial sustainability of publicly funded medicare, should be stressed. Recommendations should be advanced within the innovation agenda of the Premiers Council of the Federation and acknowledge that it can be difficult to align the priorities of stakeholder groups. This reality should not deter action on the compelling evidence that leads to the imperative for change.

Recommendation 11

Staffing guidelines for the mix of professionals in collaborative care models should be developed by professional associations (e.g., CPA, College of Family Physicians).

Recommendation 12

That demonstration projects and randomized controlled trials of innovative models of mental health care be designed through a collaboration of CPA's Practice Directorate and Scientific Directorate. These projects should include practice guidelines where they exist. Other concerned groups such as the College of Family Physicians of Canada should be invited to participate. Funding for the projects should be sought from CIHR and provincial governments.

III Context

III.1 The Issue

On one hand, it is obvious: 20% of Canadians face a mental health problem annually; these problems are left unresolved or managed with isolated pharmacological interventions. Publicly funded services are based on available physician and hospital services and do not include private practice psychologists' services. The coverage is inadequate, especially for those with limited income and others who do not have access to extended health benefits through private insurance. As well, those with extended health benefits frequently are restricted by artificial time constraints on the number of psychologist sessions per year. As a result, the burden of mental health care surpasses the public health expenditure by an estimated 20-fold.¹ Despite the intellectual logic and metrics, the problems remain unresolved. This is particularly troublesome, when the issues have been studied and quantified, over significant time, by commissions and research bodies, and there are no fundamental arguments with the need.

III.2 The Dilemma

The delivery of mental health services in Canada can be characterized as a silent crisis. An increasing demand and need is unmet by provincial and territorial health care systems and private insurers. Instead, attention has continued to focus on politically sensitive areas, such as cardiovascular interventions and joint replacement surgery. Nonetheless, a mental health disorder affects one in five Canadians with an annual societal cost of \$50 billion, as reported by the Mental Health Commission of Canada.

Historically, mental health care often resulted in institutional care; the trend back to community care and diminishing stigmatization has not been matched with appropriate community level support.

The discipline of family medicine in Canada is faced with the challenges of prevalent mental health disorders and inaccessible consulting services.² Family physicians, not infrequently, are stymied by the inability to access mental health services, whether as an insured or uninsured service. Their patients are denied required and appropriate care. Despite an awareness of the benefits of evidence-based psychological interventions, there continues to be a severe gap in the ability of patients to receive needed care.³ Many physicians have been left with the inappropriate referral of patients to emergency departments and with unsatisfactory outcomes.

Quality-Adjusted Life Year (QALY) measures and Disability-Adjusted Life Year (DALY) measures reflect risk-benefit assessments of clinical interventions. These measures of disease burden are generally accepted as valid measures of the value of medical care in terms of the quality and quantity of life. Estimates of cost per QALY indicate that psychological services fall well within the thresholds often used to determine the insurability of medical and pharmaceutical services.

III.3 The Basics

A doctoral degree is the accredited qualification for practice as a psychologist in Canadian jurisdictions. All provinces, except Newfoundland and Labrador and Prince Edward Island, have masters or accredited doctoral programs, with the length of study from four to seven years post-baccalaureate. In 2012, CPA adopted an entry-to-practice position which calls for registration at the doctoral level. The basis for this position is that the vast majority of programs in Canada, and all the accredited programs, are doctoral programs. The decision to support the doctoral standard was also voted upon by the CPA Practice Directorate, which has as its membership the provincial/territorial psychological associations and CPA. In 2009, there were 16,656 registered psychologists in Canada, a 27.5% increase during the previous nine years or an annual average annual growth rate of 2.7%. At the provincial level, 7,433 registered psychologists practised in Quebec, 3,263 in Ontario, and 2,497 in Alberta. Among provinces with the largest populations, Ontario and British Columbia (1,065) have a relatively low supply of registered psychologists in proportion to the potential population served.⁴

The distribution of registered psychologists by gender, in reporting provinces, was 69.6% female and 30.4% male, based on data from jurisdictions with 93% of registered psychologists. The distribution, by age, indicated that 11.4% were aged 25-34 years, 24.3% were aged 35-44 years, 27.4% were aged 45-54 years, and 35.4% were greater than 55 years (based on jurisdictions with 91% of registered psychologists).

III.4 History of Canadian Initiatives to Support Mental Health Care

Federal and Provincial/Territorial Government Funding

Public financial support for health care in Canada is founded in the Canada Health Act (CHA, 1984). The CHA replaced the Hospital Insurance and Diagnostic Services Act (1957) and the Medical Care Act (1966). As indicated by the titles of these two legislative landmarks in Canadian Health finance, the legislation mandated provincial coverage of hospital and physicians services, with support from the federal government. The Medical Care Act implemented recommendations of the Hall Commission (1963), including joint federal-provincial financing of a universal medical care plan that would cover medically necessary physician services. The Hall Commission report also recommended coverage of prescription drugs, prosthetic services and home care services.

The *Medical Care Act* covered virtually all physician services except cosmetic surgery and certain other procedures, which were not deemed medically necessary (e.g., sex-change surgery and in-vitro fertilization). Specified dental surgical services performed in hospitals were covered when carried out by dental surgeons, the putative rationale being to recognize that the dental surgery procedures would be insured if performed in hospital by a physician but that dental surgeons were normally the designated providers and that they had hospital privileges to perform the services.

Mental health services by physicians were covered by the Medical Care Act, but mental health services by other professionals were not. At that time, provinces operated psychiatric hospitals as separate entities from general hospitals and publicly insured mental health care was provided in these hospitals, in provincially operated mental health outpatient clinics, or by physicians in private practice.

The outpatient clinics were typically operated by divisions within provincial ministries of health, with a specific mandate to be responsible for mental health care.

The CHA included criteria for comprehensiveness of provincial plans that were similar to the scope of coverage under the former legislation.⁵ The stated objective of the CHA is, to protect, promote and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health services without financial or other barriers (Section 3). The CHA defines insured health services as, hospital services, physician services and surgical-dental services provided to insured persons... (Section 2). The definition of hospital specifically excludes *a hospital or institution primarily for the mentally disordered* and institutions that provide residential care.

It could be argued that the exclusion of institutions for the treatment of mental disorders from the CHA ambit conflicts with the objective of restoring mental health. It is not clear if this exclusion in the *Hospital Insurance and Diagnostic Services Act* contributed to the trend to close dedicated psychiatric hospitals in the provinces and to transfer care that had previously been provided to their clients to acute care hospitals or to community settings. In any event, this point is not relevant to the CHA; hospital funding under the Act prior to 1977 was based on national average per capita cost but the funding criterion was changed to a combination of indexed block grants and tax points in 1977.

The CHA does specify that the definition of medical practitioners whose services are covered under the Act can extend beyond physicians and dentists by specifying that:

In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

This wording indicates that provinces could include the services of psychologists or other regulated health professionals under their health care insurance plans, at least for services that overlap with those provided by physicians, such as psychotherapy and counseling. Provinces and territories have not included psychologists services under their fee-for-service insurance plans, however, although psychologists are employed in hospitals and other provincially operated facilities that provide mental health care.

Two major reports were produced in 2002 with a view to setting criteria for the future of publicly financed health care in Canada. A report from The Standing Senate Committee on Social Affairs, Science and Technology in October 2002, known as the Kirby Report, recommended numerous actions by the federal government to make publicly financed health care more efficient and sustainable.⁶ These recommendations included enhanced funding for provinces to establish multi-disciplinary primary care groups, with the provisions that these groups should:

strive to ensure that services are delivered by the most appropriately qualified health care professional
and

utilize to the fullest the skills and competencies of a diversity of health care professionals, including particularly nurse practitioners. (Chapter 4)

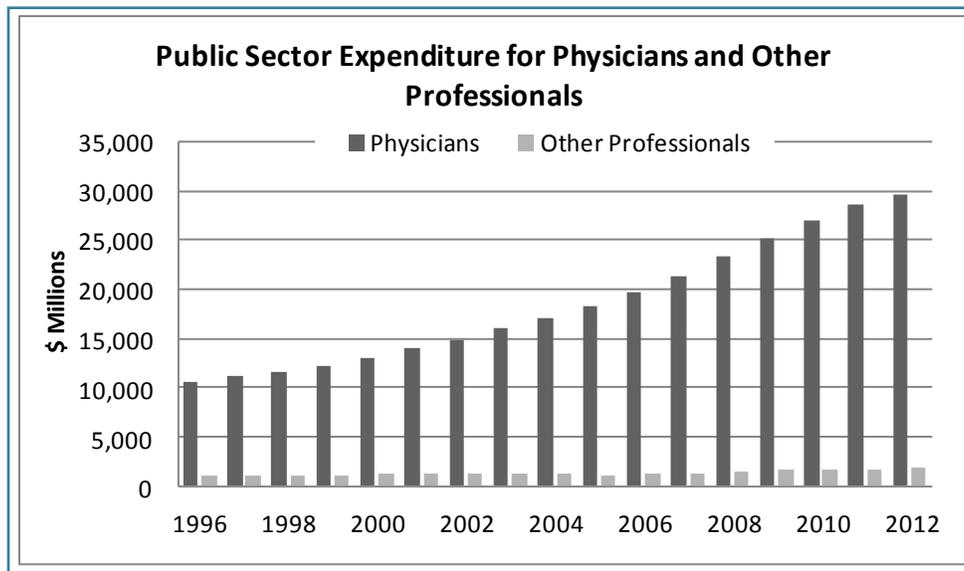
The report recommended an additional \$50 million a year in federal funding for primary care reform. In total, reforms proposed by the Committee were expected to cost an additional \$5 billion per year, which would be raised through a dedicated increase of 1.5 percentage points in the federal sales tax or a national health insurance premium, with contributions based on family income. The proposed new funding was to be provided through earmarked transfers to the provinces, overseen by a national commission, and not through the Health and Social Transfer, used to distribute funding for the CHA.

The report of the Commission on the Future of Health Care in Canada, known as the Romanow Commission, was released in November 2002.⁷ It recommended that the health care system become more responsive, efficient, and accountable to Canadians. Detailed recommendations included additional funding for primary health care reform, the establishment of the Canada Health Council and updating of the CHA. Funding proposals included a floor for federal cash funding of 25% of the cost of insured health services under the Canada Health Act and new targeted funds for five priority areas, including primary care and home care. Estimates of the annual costs of new home care programs were \$970 million, of which \$568 million would be for home mental health management (other home care categories were post-acute medical care, post-acute rehabilitation and palliative care).

Both the Kirby and Romanow commissions endorsed new approaches to care using health care professionals in the most efficient manner. The Romanow commission recommendations for mental health care envisioned an additional one-half billion dollars per year for home mental health care. The Kirby Commission scheduled a report on mental health as part of the future work arising from its deliberations, which was completed by a Senate Standing Committee. Following that report, the federal government established the Mental Health Commission of Canada.

In the years following implementation of the *Medical Care Act*, there was an expansion of provincial programs, which insured services by other providers. Some of these programs were designed to cover overlapping services that were provided both by medical doctors and by other professionals (such as eye-care and exams by optometrists). Other high priority programs included children's dental plans and prescription drug coverage for seniors and persons eligible for income support programs. By the time the CHA was implemented in 1984, public sector fiscal policy had shifted to cost control. This shift was made more urgent during the federal government budget restraint period in the early 1990s, a period when public sector health expenditures contracted in real (constant dollar) terms. Between 1992 and 1996, public sector health expenditure in 1997 dollar values decreased from \$54.7 billion to \$53.5 billion.⁸

Public sector health expenditure has increased since 1996 but the increases for health care professionals have been concentrated in expenditure for physicians services, demonstrated in the following figure. Preliminary estimates of public sector expenditure in 2011 for physicians' services were \$28.6 billion, an average annual increase of 6.8% since 1995, while expenditure for the services of other professionals was estimated to be \$1.7 billion, an average annual increase of 3.5%, since 1995.



Source: CIHI (2012); data for 2011 and 2012 were classified as preliminary forecasts

Public sector health expenditures are dominated by expenditures of the provinces and territories. Between the 1995-1996 and 2009-2010 fiscal years, health expenditure increased from 32.3% to 38.2% of provincial and territorial government expenditures for all programs (excluding debt servicing charges).⁹ This trend is one of the key factors that have raised concerns about the sustainability of public finance for health care in Canada. In this context, it is difficult to argue for new programs that would lead to increased expenditure. Initiatives that improve efficiency while improving health care outcomes are increasingly important, however, and these goals (efficiency and health outcomes) are key considerations in current initiatives by the Premiers Council of the Federation to achieve innovation in publicly financed health care. This was emphasized by the Drummond report, which called for Ontario to fund mental health and addictions services, even in these trying economic times, with new and reallocated monies because of the economic benefits.

Mental Health Initiatives by Stakeholder Groups

Several initiatives have been undertaken in recent years to address the need for improved mental health among Canadians and deficits in the availability of mental health services.

Canadian Collaborative Mental Health Initiative (2003 - 2008)¹⁰

The Canadian Collaborative Mental Health Initiative (CCMHI) was developed in 2003 by a consortium of twelve national organizations. Health professionals' organizations participating in CCMHI consisted of physicians (family physicians and psychiatrists), mental health nurses, psychologists, occupational therapists and pharmacists. Allied professions consisted of social workers and dietitians. Other organizations consisted of the Canadian Mental Health Association and the Canadian Alliance on Mental Illness and Mental Health. The CCMHI was funded by Health Canada under the Primary Health Care Transition Fund, which was created by the federal government in 2000 to promote change and innovation in models of primary care.

CCMHI produced twelve research reports documenting mental health issues in Canada and internationally; characteristics of collaborative care and primary care; a review of policy affecting collaborative care across Canada; interprofessional education and health human resources in collaborative mental health care. These reports include an annotated bibliography on the integration of mental health care in primary care and an assessment of the state of the evidence about the effectiveness of collaborative mental health care. Key findings for the CPA, documented in the papers, are listed in the following box.

Conclusions from the CCMHI Research Papers that Support a Business Case for Improved Access to Collaborative Mental Health Care in Canada

- i. Activities for the expansion of mental health care and primary care reform are underway in all provinces and territories.
- ii. The research literature documents key success factors for collaborative mental health care as including (i) consumer (patient) involvement in treatment choices, (ii) family and community support, (iii) choices between cognitive therapy and pharmaceuticals depending on severity and consumer preferences, (iv) the use of clinical guidelines and (v) follow-up services where necessary.
- iii. Knowledge transfers between primary care providers, mental health specialists, consumers and families are important to successful collaborative care models.
- iv. Enhanced funding, appropriate organizational structure (e.g., co-location of different providers, peer support and education) and resolution of policy or legal considerations (e.g., malpractice insurance) are important determinants for success of collaborative models.

Twelve toolkits were developed and distributed to assist health care providers, planners, educators, consumers of mental health care and their families. The toolkits explain the nature of collaborative initiatives, interprofessional collaboration, mental health care and ways to establish collaborative care initiatives. The toolkits for health care providers deal with the mental health needs of specific population groups and strategies to address these needs.

CCMHI adopted nine principals for collaborative mental health care, which stress that mental health care should be viewed as a continuum consisting of individuals, their families, community supports, primary care providers and mental health professionals. Relationships between mental health providers should be characterized by mutual respect and trust and supported by appropriate funding models. Lastly, mental health care models should be cost effective in terms of results for consumers and the relative costs of providing care.

CCMHI produced two sets of major reports under Phase 1 and Phase 2. A final report on Phase 1 (2006) summarizes CCMHI activities, research reports, toolkits and strategies to advance collaborative mental health care.¹¹ A final report on Phase 2 (2008) consists of summaries of

consultations carried out in Nova Scotia, Manitoba, and Saskatchewan after the completion of Phase 1.¹² The consultations covered present initiatives in each province, barriers to expansion of collaborative mental health care, opportunities and recommendations for future activities in each of the three provinces.

Enhancing Interdisciplinary Collaboration in Primary Health Care (2004 to 2006)

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) initiative, which was also funded by the Primary Health Care Transition Fund, was formed by ten stakeholder organizations to develop a framework and process to implement primary care models featuring greater collaboration among professionals. Participants in the EICP included many of the organizations that were active in the CCMHI initiative. The EICP work was carried out during 2005 and 2006 and was able to draw on the knowledge gained through the CCMHI and previous experience with collaborative primary care models in Canada. In the words of the steering committee, the EICP: . . . *has been designed to create a better understanding of how the primary health care system should develop, and to identify what policies, principles and operational infrastructures are needed to support such a system.*¹³

The framework for implementation developed by the EICP contained seven elements, shown in the following box. Significant accomplishments of the EICP included sign-off on the framework by the ten organizations participating and agreement of the Canadian Medical Protective Association (CMPA) to change its prior recommendations against collaborative practice, which had reflected a concern that physicians would bear an inordinate risk of liability.¹⁴

Framework for Implementation of Enhanced Interdisciplinary Collaboration

Health Human Resources

Research on supply, demand, productivity and demographics of HHR are required for planning.

Funding

Innovative funding models are required to provide incentives and institutional structures for successful collaboration.

Liability

An integrated approach to liability insurance that recognizes the role of shared decision-making and clearly articulated scopes of practice is required to establish an enabling legal environment.

Regulation

Support by regulatory bodies and appropriate legislation governing regulation.

Information and Communications Technology

Appropriate IT is required to ensure continuity of information between members of collaborative teams.

Management and Leadership

Strong administrative support and appropriate governance structures are required for effective management and leadership.

Planning and Evaluation

Centralized administrative support is required for evaluation of primary care collaboration, including outcomes and quality improvement.

Source: EICP Framework

The Mental Health Table was formed in 2009 by a number of associations representing health care providers active in mental health. The purpose of the Table is to provide a venue for member organizations to share information and discuss issues relevant to advancing mental health and mental health care in Canada. A national Mental Health Table Forum was held in Ottawa during October 2010 with a view to advancing mental health promotion and mental health care delivery. Eighty delegates attended, representing government, consumers and 12 professional associations. Most of the organizations active in CCHMI and the EICP participated. The Forum produced a report in 2011 summarizing its activities and recommendations.¹⁵ Twenty-four recommendations, within eight theme areas were adopted; they are summarized in the following box.

Recommendations of the Mental Health Table Forum

Funding

Review and improve funding models to ensure access to necessary services and supports.

System Structure

Develop and maintain systems that respond to consumer need and facilitate efficiency and effectiveness.

Organization, Integration and Collaboration

Enhance organization, integration and collaboration with stakeholders across all concerned sectors.

Consumer Voice

Include consumers at the decision-making table.

Education and Communication

Enhance mental health promotion, prevention and early identification by increasing mental health literacy and reducing stigma.

Training and Practice of Health Care Providers

Train health care providers to work collaboratively and to respond to needs of populations within a system that supports collaborative practice.

Standards and Benchmarks

Establish national standards for mental health care and develop standards for wait times for mental health services and supports. Support training in mental health to all formal and informal health care providers.

Advocate for Change to Enhance Access

Advocate for legislative change to enhance access to appropriate services and providers.
Create parity between mental health and physical health funding and services.

Sources: Mental Health Table Forum Report (p. 18-20); CPA website

Integrating Needs for Mental Wellbeing into Human Resource Planning (Project IN4M) (2010-2011)

Project IN4M was planned as a three-phase research project designed to develop a system for needs based human resource planning for mental health. IN4M was funded by Health Canada and the Canadian Mental Health Association. IN4M's overall goal is to improve accessibility to high-quality mental-health services *through needs-based predictive modelling of health, social, education, criminal justice and private sector human resources — including informal caregivers.*¹⁶

The Phase 1 project report planning concept is a comprehensive model in terms of (i) the continuum of care (starting with family care givers and progressing to regulated health professionals); (ii) the community and ambulatory care focus; and (iii) the inclusion of the major delivery domains - primary care, tertiary care, private delivery, work place, schools, jails and prisons, social welfare services.

Project IN4M Conclusions

- i. A health human resource planning focus is required as part of a Canadian Mental Health Strategy.
- ii. Canada has the research capacity to develop a needs-based predictive model for human resources in mental health.
- iii. Important next steps include developing a proof-of-concept HHR planning tool focused on key mental health diagnoses and specific occupations.

Source: IN4M Final Report

Stages 2 and 3 of the project are being actively considered with a view to obtaining funding for further work in the near future.

Mental Health Commission of Canada

The Mental Health Commission of Canada (MHCC) was appointed by the federal government in 2007. It has a 10-year mandate, lasting until 2017. The Commission has an ambitious agenda, including, *creating the country's first mental health strategy, working to reduce stigma, advancing knowledge exchange in mental health, and examining how best to help people who are homeless and living with mental health problems.*¹⁷

The MHCC was appointed as the result of a national study of mental health and addiction carried out by a Standing Senate Committee. The Committee report (2006)¹⁸ identified the need for a Mental Health Commission to provide an ongoing national focus for mental health issues. The Commission published a comprehensive health strategy in the spring of 2012.¹⁹

The Strategy report provides six strategic directions to improve mental health care in Canada. While not specific to psychologists, the priorities and key recommendations discussed under Access to Services (Strategic Direction 3) are summarized, as follows:

- i. Expand the role of primary health care in meeting mental health needs
 - Strengthen collaborative approaches to primary and mental health care
 - Integrate recovery approaches into primary health care...facilitating self-management and peer support
 - Implement guidelines for screening, services, treatments and supports
 - Ensure that people living with mental health problems and illnesses have timely access to appropriate physical health care
 - Use technology to foster collaboration, increase access to services
- ii. Increase the availability and coordination of mental health services in the community
 - Increase resources and capacity for a range of community mental health services
 - Improve coordination and collaboration across mental health, health, addictions, and other service systems
 - Set standards for wait times for community mental health services
 - Increase access to psychotherapies and clinical counseling by service providers who are qualified to deliver [evidence-based] approaches
 - Remove financial barriers to access psychotherapies and clinical counseling
- iii. Provide better access to intensive, acute, and highly specialized services, treatments and supports when they are needed
 - Establish benchmarks for the availability of intensive, acute, and highly specialized treatments
 - Adopt recovery and wellbeing approaches in policies and practices
 - Facilitate successful transitions from intensive services ... to community mental health services
 - Address barriers to equitable access to medications
- iv. Recognize peer support as an essential component of mental health services
 - Develop nationally recognized guidelines for peer support
- v. Increase access to housing with supports, and to income, employment, and education support
 - Increase the availability of safe, secure, and affordable housing with supports

- Enhance supports for people living with mental health problems and illnesses to pursue education and obtain work
- Make disability benefit programs more adaptable to the individual needs of people living with mental health problems and illnesses
- Help caregivers with better financial supports, increased access to respite care, and more flexible workplace policies

(Condensed from Canadian Mental Health Strategy, Strategic Direction 3, Pg. 53-75)

The report discusses the financial implications of mental illness in Canada, estimating an annual economic cost of \$48.5 billion. The potential lifetime cost of childhood mental disorders is estimated to be in the order of \$200 billion (pg. 125).²⁰ The report makes the following recommendations for increased expenditure on mental health (pg. 127):

- i. Increase the proportion of health spending that is devoted to mental health from seven to nine per cent over 10 years
- ii. Increase the proportion of social spending that is devoted to mental health by two percentage points from current levels
- iii. Identify current mental health spending that should be re-allocated to improve efficiency and achieve better mental health outcomes
- iv. Engage the private and philanthropic sectors in contributing resources to mental health

Premiers Council of the Federation Innovation Agenda

In January 2012, the Premiers Council of the Federation announced an initiative to establish a collaborative process to identify and promote innovation in health care. The first report from the working group leading this initiative was released in July.²¹ The report dealt with three issues: clinical practice guidelines, team-based health care delivery models, and health human resource management issues. Mental health was not addressed as an issue in the first report, but sources advise that it could come to the fore in future activities of the working group.

The working group approach was to identify models that have met with success in specific jurisdiction and have the potential to be adopted elsewhere. The models were described briefly and recommendations were made for further study by all provinces, with a view to advancing appropriate models in their own jurisdictions. The team-based models include primary care and home care after hospitalization, which are examples of models that have the potential to incorporate psychologists' care. There were no specific recommendations about expanding the types of providers covered by provincial funding.

IV Approach to the Study

IV.1 Qualitative Research

The literature review and analyses incorporated an in-depth exploration of models that have shown promise, including Canadian primary care models and the international experience. The study objective was to identify solutions that are sensitive to the Canadian health care culture and consistent with current federal and provincial initiatives and roles, including primary care reform, integrated models of care, and federal-provincial delivery and funding models.

The Report of the Mental Health Commission of Canada underlined strategic directions calling for increasing the proportion of funding allocated to mental health within extant funding envelopes for health and social services and the reallocation of spending within mental health budgets. The present growth of primary care networks in Canada, especially within collaborative care models, offers the potential to incorporate psychologists in the diverse models with funding from health authorities. The challenge is selection of administrative models that promote interdisciplinary care and collaboration that support role optimization within a non-hierarchical model.

The qualitative research pursued these concepts and analysis of success factors, insurance coverage, and impediments. This was derived from a comprehensive national and international literature research and analysis.

In addition to individual informed resources, an environmental scan was undertaken of six key sectors:

- Provincial and territorial psychological associations
- Provincial and territorial ministries and departments with responsibility for health and social services
- Provincial and territorial ministries and departments with responsibility for children and youth services
- Federal departments with responsibilities that include the provision or support of psychological services
- Private insurers
- Workers' Compensation Boards

The scan also included the acquisition, collation, and analysis of payment data to health professionals and national health expenditure trends.

IV.2 Quantitative Research

Quantitative analyses included two components. The first was a thorough literature review and analysis of relatively new programs for psychologists' care in Australia and the United Kingdom. Other international programs were studied, with those in the United States, Netherlands, and Finland reviewed in greater detail, as relevant to the context of the study mandate. The second was an analysis of the actual and potential costs of models of enhanced access to care by psychologists in Canada.

Results of the qualitative and quantitative analyses were used to develop a business case for advancing the public and private insurance funding of services provided by psychologists and reducing the gap in services provided to and required by Canadians who need mental health care.

V Environmental Scan

V.1 Introduction

The environmental scan included an assessment of the perspectives of six sectors key to this study. Confidentiality was assured to potential respondents, who were contacted initially by telephone and by e-mail. The survey was conducted electronically, using a common introduction and conclusion, and sector-specific questions. The format and content of each survey is provided in Appendix A.1 of the report.

The six sectors are, as follows:

- Provincial and territorial psychological associations
- Provincial and territorial ministries and departments with responsibility for health and social services
- Provincial and territorial ministries and departments with responsibility for children and youth services
- Federal departments with responsibilities that include the provision or support of psychological services
- Private insurers
- Workers' Compensation Boards

As well, knowledgeable resources were interviewed in person or by telephone, also with the assurance of confidentiality. The nature of their reflections is incorporated in the results of the scan, along with a variety of current media reports.

Further, payment data were analyzed to better understand the relative payments for services provided by family physicians by National Grouping System Strata and Province/Territory.²² Finally, public sector expenditures were analyzed for physicians and other professionals, between 1995 and 2012, as were total expenditures for physicians and other professionals for the same time period.²³

The results for each element of the environmental scan are summarized in the sections that follow.

V.2 Survey of Psychological Associations

Responses were received from ten provincial and territorial associations. The responses are tabulated, as follows, by jurisdiction; the more detailed elements of questioning are provided in Appendix A.1.

Newfoundland and Labrador	
Number of licensed psychologists in jurisdiction	222
Number licensed psychologists that are members	150 (est.)
Jurisdictional HR plan that includes psychologists	Formal human resource plan that will include psychologists is under development
Jurisdictional funding sources for psychologists	Health School Child and Youth Services Workers' Compensation Veterans Affairs First Nations Private insurers Self-funded
Percentage employment by sector	Health - 32% School K - 12 - 54% School - university - 1% Self-funded - 13%
Jurisdictional fee schedule for private psychologists	Hourly rate of \$150
Limitations imposed on access by funders	Annual dollar limitation Requirement of medical referral
Percentage of self-paid psychologist services	No cost in public system In private system, 80% is insured or EAP co-pay
Estimate of unmet need	Significant unmet need. 25-50% vacancy rates in province., especially in rural areas. Greatest unmet need in services for the elderly, autism spectrum disorder in adults, oncology, paediatric neuropsychology, and learning disability assessment.
Assessment of plans to expand psychologist funding	No known plans to expand.
Integrated health teams that include psychologists	Adult stroke rehabilitation team

Prince Edward Island

Number of licensed psychologists in jurisdiction	44 (2 living out-of-province)
Number licensed psychologists that are members	38
Jurisdictional HR plan that includes psychologists	None known
Jurisdictional funding sources for psychologists	Health School Corrections Child and Youth Services (contract) Workers' Compensation (contract) Department of National Defence (contract) Veterans Affairs (contract) Private insurers Self-funded
Percentage employment by sector	Health - 25% School - 30% Corrections - 3% Private insurers - 25% College student services - 6%
Jurisdictional fee schedule for private psychologists	Hourly rate of \$150
Limitations imposed on access by funders	Federal - \$1,000 Provincial - \$800 Private - \$500
Percentage of self-paid psychologist services	2-5% of all services (and about 60-70% co-paid)
Estimate of unmet need	Waiting lists in the public system are lengthy; not unusual for treatment delays to be up to 12 months and not less than 6 months. Some key services, such as community mental health and many medical units, have no access to psychologists. Delays in assessment in the public system can be 1 to 3 years (health or education), if available at all. Waiting lists in private practice are typically 6-12 months.
Assessment of plans to expand psychologist funding	Nil
Integrated health teams that include psychologists	Part-time team participation (1-2 days monthly) includes inpatient psychiatry, inpatient rehabilitation and stroke, preschool special needs, seniors' mental health, and multi-agency support teams in the school system.

Nova Scotia

Number of licensed psychologists in jurisdiction	532
Number licensed psychologists that are members	420
Jurisdictional HR plan that includes psychologists	Nil
Jurisdictional funding sources for psychologists	Health School Corrections Child and Youth Services Workers' Compensation Employee Assistance Programs Department of National Defence Veterans Affairs Corrections Private Insurers Self-funded
Percentage employment by sector	Health - 30% School - 21% Corrections - 1% Child and Youth Services - 2% Department of National Defence - 1% Self-funded - 36% University services - 7%
Jurisdictional fee schedule for private psychologists	Hourly rate of \$150
Limitations imposed on access by funders	Variable limitations in dollars and service volume
Percentage of self-paid psychologist services	Estimated to be 25% for self-pay and 75% co-pay
Estimate of unmet need	40-50% of need is unmet
Assessment of plans to expand psychologist funding	Nil
Integrated health teams that include psychologists	Small teams in the two largest hospitals (one adult and one paediatric)

New Brunswick

Number of licensed psychologists in jurisdiction	399
Number licensed psychologists that are members	399 (licensed and associate and out-of-province)
Jurisdictional HR plan that includes psychologists	Under consideration
Jurisdictional funding sources for psychologists	Health School Corrections Child and Youth Services Workers' Compensation Employee Assistance Programs Department of National Defence Veterans Affairs Private insurers Self-funded
Percentage employment by sector	Health - 14% School - 12% Child and Youth Services - <1% Workers' Compensation - <1% Community Mental Health - 18% Department of National Defence - 1% Corrections - 6% Private insurers - 40% University services - 9%
Jurisdictional fee schedule for private psychologists	Hourly rate of \$150
Limitations imposed on access by funders	Annual dollar limits; EAP and public services have a soft cap on service volume
Percentage of self-paid psychologist services	Self-pay 5% and co-pay 55% and publicly funded 40%
Estimate of unmet need	40-50% of need is unmet
Assessment of plans to expand psychologist funding	Nil - although the shortage of psychologists in the public sector is under examination at the provincial level
Integrated health teams that include psychologists	Multi-disciplinary teams are most commonly seen in a hospital setting. Otherwise, psychologist services are more consulting and less team-based

Quebec

Number of licensed psychologists in jurisdiction	8,500 (7,800 active)
Number licensed psychologists that are members	8,500
Jurisdictional HR plan that includes psychologists	Formal plan
Jurisdictional funding sources for psychologists	Health School Corrections Child and Youth Services Workers' Compensation Veterans Affairs Private insurers Self-funded
Percentage employment by sector	Health - 20% School - 10% Corrections - <5% Child and Youth Services - 2% Veterans Affairs - 1%
Jurisdictional fee schedule for private psychologists	Coverage for private practice by government for motor vehicle accidents, workers' compensation, and victims of crime at hourly rate of \$86.80
Limitations imposed on access by funders	Yes - highly variable
Percentage of self-paid psychologist services	Not available
Estimate of unmet need	Not available
Assessment of plans to expand psychologist funding	Measures are being contemplated to attract and retain psychologists in the public sector, especially health and education services, where compensation has not been competitive
Integrated health teams that include psychologists	Available at http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2006/06-914-05.pdf

Ontario

Number of licensed psychologists in jurisdiction	3,378 (excludes academic, inactive, retired)
Number licensed psychologists that are members	1,500 (est.)
Jurisdictional HR plan that includes psychologists	Nil
Jurisdictional funding sources for psychologists	Health School Corrections Child and Youth Services Workers' Compensation Department of Natural Defence Veterans Affairs Private insurers Self-funded
Percentage employment by sector	Health - 25% School - 15% Corrections - 2% Child and Youth Services - 0.7% Workers' Compensation - 1% Motor Vehicle - 2% Department of National Defence - 0.2% Veterans Affairs - 0.2% Universities and Colleges - 9% Private insurers - 26% Self-funded - 11% Employee EAP - 1% Unspecified - 5%
Jurisdictional fee schedule for private psychologists	Hourly rate at \$220
Limitations imposed on access by funders	Annual dollar limits (\$300 to \$1,000), sessional dollar limits, service volume, (unnecessary) physician referral Rate variation among third parties: Veterans Affairs at \$220 per hour, Workers' Compensation at \$67 per half hour or less with cap, Motor vehicle up to \$177 per hour (with cap)
Percentage of self-paid psychologist services	30% of private patients are self-pay

<p>Estimate of unmet need</p>	<p>Significant unmet need in part related to population: psychologist ratio of 1:3,200 (compared to Quebec at 1:950 and Alberta at 1:1,500) – acknowledging problems of reliance on benchmark ratios</p> <p>Ongoing school psychology and criminal justice vacancies</p> <p>Reduction of federal transfer payments led to reduction or elimination of hospital-based psychological services – never reversed</p> <p>Psychological services deficient in hospital-based mental and physical health programs and services</p> <p>Private practitioners typically have a 3-month waiting list</p> <p>Serious gaps in child- and youth-based care</p>
<p>Assessment of plans to expand psychologist funding</p>	<p>Nil planned officially, but provincial mental health strategy includes enhanced mental health services, generally, and the Drummond Report called for increased access to psychological services</p>
<p>Integrated health teams that include psychologists</p>	<p>MOHLTC includes available positions in family health teams, but metrics are not well-defined</p>

Manitoba	
Number of licensed psychologists in jurisdiction	181
Number licensed psychologists that are members	145
Jurisdictional HR plan that includes psychologists	Nil
Jurisdictional funding sources for psychologists	Health Schools Corrections Child and Youth Services Workers' Compensation Department of National Defence Veterans Affairs Private insurers Self-funded
Percentage employment by sector	Health - 25% School - 2% (PhD only) Corrections - 2% Child and Youth Services - 2% Veterans Affairs - 2% Private insurers - 2% Self-funded - 63%
Jurisdictional fee schedule for private psychologists	Varies, with recommendations being: \$155 per 50 minutes \$95 per 80 minutes (group) \$155 per hour (assessments) \$1,120 per day (legal consultation)
Limitations imposed on access by funders	Varies from nil by Workers' Compensation to caps by GWL based on number of sessions and proposals from medical coordinators and rehabilitation consultants; otherwise, \$350 - \$1,500 annually if self-referred or by a physician, depending on company
Percentage of self-paid psychologist services	50-75% are co-paid, but with coverage of limited sessions (as low as 2-3 per year)

Estimate of unmet need	Significant barriers to accessing needed services, particularly in the publicly funded sectors (wait lists for private services are not significant) where the wait times can be longer than one year. CIHI reports that Manitoba has the lowest number of psychologists per 100,000 among provinces
Assessment of plans to expand psychologist funding	Nil

Integrated health teams that include psychologists

The largest group of publicly funded psychologists works within the Department of Clinical Health Psychology, which is separately funded with its own administration and management under the Faculty of Medicine (it is its own department and does not fall under Psychiatry). This structure allows for all funding to move directly through the department to fund the psychologists working in various programs across the province.

There is one psychologist who works one day a week in a family medicine clinic that trains family medicine residents. He is integrated into their service by providing brief consultations to physicians/residents/other disciplines, brief therapy or assessment with patients, and teaching residents (e.g., CBT, what is a panic attack, improving compliance in patients). The clinic would be very interested in having him work full-time, but there is a lack of funds to increase his time. He also has obligations to working in another area of the community hospital.

There is a psychology position available in a Shared Care program. This psychologist works primarily as a consultant to 100 physicians and counselors around the city. Occasionally, the psychologist will briefly see a patient for therapy or a brief assessment to determine whether a referral is required to another psychology program for additional services.

There are psychology positions in two multidisciplinary teams – Concordia Hip and Knee Rehabilitation Clinic and the Bariatric Program. Although the psychologist is integrated into the team, they report to the Head of the Department of Clinic Health Psychology. It is similar to the structure of a physician working within this type of program. There are also psychologists working either part-time or full-time in Pain Clinics, the FASD Centre, or inpatient psychiatric units.

There is at least one psychologist who is co-located in a private family medicine practice. She functions as a private practitioner.

Saskatchewan

Number of licensed psychologists in jurisdiction	500 (est.)
Number licensed psychologists that are members	230 (est.)
Jurisdictional HR plan that includes psychologists	Nil
Jurisdictional funding sources for psychologists	Health School Corrections Child and Youth Services Workers' Compensation Department of National Defence Veterans Affairs Private insurers Self-funded
Percentage employment by sector	Not available
Jurisdictional fee schedule for private psychologists	Hourly rate at \$140
Limitations imposed on access by funders	Nil for public services; others are limited by funding source
Percentage of self-paid psychologist services	Not available
Estimate of unmet need	Waiting lists for publicly funded services measured in months
Assessment of plans to expand psychologist funding	Nil
Integrated health teams that include psychologists	Not tracked but aware of examples in some rural areas and areas of health psychology

Alberta

Number of licensed psychologists in jurisdiction	2,215
Number licensed psychologists that are members	1,646
Jurisdictional HR plan that includes psychologists	Plan is not specific for psychologists
Jurisdictional funding sources for psychologists	Health Schools Corrections Child and Youth Services Workers' Compensation Department of National Defence Corrections Private insurers Self-funded
Percentage employment by sector	Health – 20% School – 13% Corrections – 3% Child and Youth Services – 3% Universities and Colleges – 13% Private insurers – 15% Self-funded – 5%
Jurisdictional fee schedule for private psychologists	Hourly rate at \$180
Limitations imposed on access by funders	Both dollars and service volume
Percentage of self-paid psychologist services	39% paid directly by client without insurance or other third party contributions
Estimate of unmet need	Approximately 40% at level of community mental health
Assessment of plans to expand psychologist funding	Nil
Integrated health teams that include psychologists	In the Calgary zone, there are 23 psychologists in primary care models (6 – shared care; 17 – behavioural); as well, there are 4 in Red Deer, 6 in Edmonton, and 1 in Lethbridge

British Columbia

Number of licensed psychologists in jurisdiction	1,000 (est.)
Number licensed psychologists that are members	700 (est.)
Jurisdictional HR plan that includes psychologists	Unknown
Jurisdictional funding sources for psychologists	<ul style="list-style-type: none"> Health School Corrections Child and Youth Services Workers' Compensation Victims of Crime ICBC Family Services Victims of Residential Abuse Department of Defence Veterans Affairs Corrections Private insurers Self-funded
Percentage employment by sector	Unknown
Jurisdictional fee schedule for private psychologists	Hourly rate at \$175
Limitations imposed on access by funders	<p>Crime Victim Assistance will pay \$105 per hour for up to 48 sessions; ICBC pays \$145 per session for up to 8 sessions – extensions may be provided, but this usually does not occur unless the claimant has a lawyer; DND, VA, RCMP pay approximately \$180 per hour; Corrections has salaried psychologists and the rate depends on the level (e.g., supervisory psychologists are paid more; new psychologists are paid less); private insurers range from \$300 per person per calendar year to \$2500 per person per calendar year</p>
Percentage of self-paid psychologist services	<p>100% self paid - probably 10-20%.</p> <p>Most people who have no coverage and no ability to self-pay will go without treatment.</p> <p>Co-paid: probably about 80%</p>
Estimate of unmet need	<p>Estimate about 70% considering that some people receive some coverage, but a very limited number of sessions are covered and the need is greater than the number of sessions given.</p>

Assessment of plans to expand psychologist funding	Association advocating to provincial government
Integrated health teams that include psychologists	Some teams are located within the hospital services (secondary and tertiary care, such as the brief assessment unit at VGH)

V.3 Survey of Provinces and Territories - Health

Responses were received from ten provincial and territorial ministries or departments of health.

One provincial response was brief in stating that health authorities hire psychologists to provide addiction and mental health services. Payment is through operational budgets but no other metrics were made available.

One territorial response confirmed the employment of psychologists in two of the eight health authorities; the services are focused largely on family counseling to community members. Otherwise, public funding is not provided for private psychological services. While the need for psychological services is described as high, there are no current plans to reassess public coverage for these services, the limiting factor being available resources. That notwithstanding, it is considered possible that the expanded presence of integrated, primary health care teams could influence the decision on expanded public coverage.

A second territorial response indicated that psychologists are not funded through any government department or agency and there are no plans to expand the coverage at this time. Psychologists are not eligible for funding because of a legislated requirement for a practitioner to be a physician in order to qualify for public funding for an insured service. In this territory, psychologists are not a regulated profession. While, until now, there have been no metrics available to define need, it was stated that inclusion of psychologists in integrated teams could be part of future primary care reform. The evidence, as suggested in the environmental scan, support the redirection of policy and funding thrusts.

Responses from the remaining six provinces are presented in tabular formats. For the exact wording of the questions, please refer to Appendix A.1.

Element	Jurisdiction 1
Current public funding for psychologists	88 funded positions
Psychologists as salaried employees	Nil
Definition psychologist	Licensed by College
Public funding for private psychologists	Nil
Impact of integrated primary care teams	Nil
Assessment of unmet need	Definite for testing and forensic
Future considerations	No planned reassessment

Element	Jurisdiction 2
Current public funding	Public health and social services
Psychologists as salaried employees	All salaried – no data on numbers
Definition psychologist	PhD and licensed by College
Public funding for private psychologists	Nil
Impact of integrated primary care teams	Nil
Assessment of unmet need	Unknown
Future considerations	No planned reassessment

Element	Jurisdiction 3
Current public funding	Psychologists in mental health and medical units
Psychologists as salaried employees	Some positions are contract – 7.5 are FTE
Definition psychologist	Licensed by College
Public funding for private psychologists	Nil
Impact of integrated primary care teams	Still to be defined
Assessment of unmet need	High
Future considerations	Restriction to PhD and MA

Element	Jurisdiction 4
Current public funding	Employment by regional health authority
Psychologists as salaried employees	65 of 207 are salaried employees
Definition psychologist	Legislation
Public funding for private psychologists	Nil
Impact of integrated primary care teams	Nil
Assessment of unmet need	23% vacancy rate and 18-month waiting list
Future considerations	Nil

Element	Jurisdiction 5
Current public funding	PhD educational bursaries
Psychologists as salaried employees	District health authorities
Definition psychologist	PhD program registration
Public funding for private psychologists	Nil
Impact of integrated primary care teams	Nil
Assessment of unmet need	Rests with health authorities
Future considerations	Rests with health authorities

Element	Jurisdiction 6
Current public funding	62 psychologists employed by regional health authorities, within community and hospital settings (48 urban and 14 rural); plus, 4.6 FTE at a tertiary psychiatric facility
Psychologists as salaried employees	62 as above
Definition psychologist	Not available
Public funding for private psychologists	Nil
Impact of integrated primary care teams	Nil
Assessment of unmet need	Recognized as a valuable component of delivering mental health services; unmet need not quantified
Future considerations	Considering the potential benefit of access to psychologist services within a primary care network system

V.4 Survey of Provinces and Territories - Children or Youth Services

Responses were received from two provincial and territorial ministries or departments with responsibility for children or youth services.

The provincial response indicated that 70 psychologists are directly employed by the ministry as part of community-based services, an adolescent treatment centre, youth forensic psychiatric services, and special needs, such as autism assessment. The salary grid for full-time work ranges from \$73,762 to \$96,183 annually, not including benefits. As well, funding is provided through contracts with agencies and private practitioners. The contract funding is based on the hourly rate of \$160 to \$175; psychologists providing these services require registration with the provincial college.

Regional feedback to the ministry confirms unmet need, in some communities, occasionally, for extended periods of time. Available local research suggests that the overall demand for mental health services exceeds service capacity, including a Canadian study that found only one in six children in need was receiving care.

Concern was expressed at the ministry that continuation of a medical model would exacerbate the gap between need and supply.

The territorial response confirmed the employment of psychologists in two of the eight health authorities; the services are focused largely on family counseling to community members. Otherwise, public funding is not provided for private psychological services. While the need for psychological services is described as high, there are no current plans to reassess public coverage for these services, the limiting factor being available resources. That notwithstanding, it is considered possible that the expanded presence of integrated, primary health care teams could support the expansion of public coverage.

Agency interviews, such as the Children's Aid Society, suggest a serious crisis in access to psychologists' services, and disappointment in the low level of contribution by the ministry and departmental representatives with direct responsibility for children and youth services. Nonetheless, where feedback was provided from this broad sector, the potential for change and realignment of resources exists.

V.5 Survey of Federal Government

Corrections Services Canada (CSC) provided the only response from four federal government departments that were surveyed. CSC is the single largest employer of psychologists in Canada; overall, CSC has 19,000 employees, with 304 FTE positions allocated to psychologists.²⁴ In 2010-2011, 52 of the psychologist positions were held by non-licensed incumbents (provincial); the filled complement in that fiscal year was 219. Overall, the ideal complement is unknown; although, the vacancy rate is reasonable steady at 25%. The vacancies have been exacerbated by federal budget cuts and subsequent removal of positions. The licensing requirement of PhD or Masters degree varies by jurisdiction.

Probably, the key barrier to achieving a full complement is the salary scale being 25% lower than that of provincial counterparts. As well, CSC psychologists have significant concerns about their roles; the historical focus has been risk assessment over therapy; ideally, the risk assessment could be provided by others, trained in these skills, and supervised by psychologists.

CSC has significant concerns regarding access to mental health services by federal offenders. The ideal role is primary access to psychologists and, thereafter, as indicated, to psychiatrists; however, there is a significant mismatch of capacity and need. Of the offenders entering federal corrections facilities, 36% of males and 60% of females are considered in need of mental health services.

Probably, the key barrier to achieving a full complement is the salary scale being 25% lower than that of provincial counterparts. As well, CSC psychologists have significant concerns about their roles; the historical focus has been risk assessment over therapy; ideally, the risk assessment could be provided by others, trained in these skills, and supervised by psychologists.

The unique skill sets, required for forensic psychology, are not addressed by every university or through appropriate preparation through the regulatory bodies. The austere and difficult environment of federal correctional facilities offers unique challenges that require preparation at universities with proximity to the penitentiaries.

Addressing the supply and demand difficulties at the federal level would include:

- Budget restitution
- Partnerships with universities
- Academic curriculum reform
- Enhanced continuing education and professional development for forensic psychologists
- Attention to the roles of forensic psychologists, as therapists rather than assessors; the assessment function could be assumed by others and supervised by psychologists

V.6 Survey of Private Insurers

One response was received from large Canadian private insurers that were surveyed. It provides evidence of the magnitude of the provision of psychologist services through the private insurance industry. While the remaining private insurers and the Canadian Life and Health Insurance Association declined participation in the survey due to concerns of releasing corporate information despite anonymity, the results are considered illustrative (on a scaled basis), since mental health issues are the major cost centre to these organizations.

The respondent provides a full range of hospital and extended health benefits, covering 9,000,000 lives, including plan members and family members. In 2011, payments were \$4.1 billion, including drugs, dental, and other medical and extended health benefits. Of this total, approximately \$2.7 billion covered services by health professionals, namely dentists, optometrists, chiropractors, and psychologists. Of this total, \$28.5 million was paid to psychologists.

Services provided by private practice psychologists are included in standard group health benefits and, optionally, in individual plans. The eligibility of a psychologist for payment through the plans is defined by licensure in the particular jurisdiction. A typical annual limitation to payments is \$500, although this can vary by plan sponsor.²⁵

The amounts provided include Administrative Services Plans. No changes in the approach to coverage are anticipated.

V.7 Survey of Workers' Compensation Boards

Three responses were received from provincial and territorial Workers' Compensation Boards; all confirmed funding for psychologist services.

The first board has identified the goal of psychological services, as identifying the worker's individual psychological health needs, to achieve an optimum state of good health, and to return the worker to healthy, productive employment. It provides funding for psychologist services on a case-by-case basis, upon referral from a physician or on the recommendation of a tiered services health care provider. The eligibility of a participating psychologist is defined by provincial statutes, regulations, and guidelines, and must include registration with the provincial college. Private psychologists are funded through a fee schedule that is updated to maintain parity with similar services in other jurisdictions. The service limitations, currently under review, are set at six treatment sessions, with an additional six, if approved by a WCB medical advisor.

The second board provides funding for psychologist services to injured workers, including private psychologists, with approximately 100 clients receiving annual individual counseling, and multidisciplinary services, that include psychologists, for another approximately 500 clients. The eligibility of a participating psychologist is defined by provincial licensure, in good standing. When the services of a private psychologist are enlisted, there is no set fee schedule or board hourly rate. These services are not subject to limitations, beyond the requirement of ongoing benefit to the client. As such, there is no sense of unmet need in this population.

The third board provides funding for psychologist services to injured workers on an hourly or program basis. There is uncertainty with respect to the number of services provided annually, due to mixed settings of single providers and multidisciplinary clinics. The eligibility of a participating psychologist is defined by registration with the provincial college, which requires Masters or PhD credentials. The fees are negotiated with the provincial psychologist association and are integral to service contracts, for which private psychologists are invited to apply. Single psychologists provide both assessment and treatment services; multidisciplinary teams, which include psychologists, focus on occupational rehabilitation, chronic pain, brain injury, and traumatic psychological injury. There are limits to the service volumes; however, these are fairly liberal with only intermittent confirmation of a positive response to treatment. While some areas of the province have limited resources, the overall needs for psychologist services are being met for this sector in this jurisdiction.

V.8 Targeted Interviews and Related Reports

Following are key points abstracted from interviews with leaders with expertise in access to mental health services in Canada, in addition to recent reports of related issues:

- As articulated by a former provincial Deputy Minister of Health, enhancement of access to mental health services is an unquestioned need; redressing the need through system and funding changes is paramount
- Achieving system and funding changes requires leadership and focus
- Integrated and multidisciplinary care is fundamental to service expansion and enhanced access to mental health services
- Expression of inequity regarding access, for those requiring mental health services, to psychologists when public funding supports the provision of such services by physicians who are not well-trained in the area²⁶
- Public/private opportunities hold potential, with the public sector contracting with the private sector to provide mental health services
- Patients are at least as involved, if not more involved, in mental health care as they are in physical health issues; organizations, with a leadership role in the management of mental health issues, would benefit by an increased patient role in their governance and policy derivation
- Community care is preferred over institutional care
- There is an historical pattern of psychologists being bypassed in funding models for mental health services
- From a letter to the editor in the *Globe and Mail*, *While some progress is being made – the Mental Health Commission of Canada, for instance, has recommended a national strategy to deal with the mental health needs of young people – your editorial is right on in warning where the continued neglect will lead – either to jail or the cemetery.*²⁷
- From the *New York Times*, *Battling a mental illness often means being isolated – from family, from society, from oneself. With a correct diagnosis, or any diagnosis, often taking years to receive, the road to stability can seem frustratingly long. Federal government statistics show that about one in four American adults has a psychiatric disorder in any given year considered the leading cause of disability in this country.*²⁸
- From the *Globe and Mail*, *In any given year, one in five people in Canada experiences a mental health problem or illness – that’s nearly seven million Canadians, each with family, friends, and colleagues preventing conduct disorders in just one of the 85,000 Canadian children currently affected would result in lifetime savings of \$280,000 A report this month from Public Health Ontario and the Institute for Clinical Evaluative Sciences indicates that the burden of mental illness*

and addiction in Ontario is more than 1.5 times that of all cancers combined, as reflected by premature mortality and reduced functioning Canada spends considerably less on mental health than several comparable countries, with seven cents out of every public health-care dollar (7 per cent) going to mental health far below the 10 per cent to 11 per cent of public health spending devoted in countries like New Zealand and Britain Canada can't afford not to invest in the future mental health and wellbeing of its population.²⁹

- *From the Globe and Mail, is one of 3,900 Afghanistan veterans the Canadian Forces estimate will be diagnosed with some form of occupational stress injury (OSI) within four years of coming home – 13 per cent of the 30,000 deployed nor do those statistics count the spouses and children who suffer at home³⁰*
- *From the Agency for Healthcare Research and Quality, Primary care clinicians are not fully trained to diagnose or treat mental health problems, yet people with these conditions typically are seen in primary care more than any other setting To make matters worse, referrals to community-based mental health providers are a persistent problem Depression and other mental health problems are undiagnosed or inadequately treated, inappropriate psychotropic drugs are prescribed with little follow-up, and the contribution of these mental health problems to chronic disease symptoms is often overlooked The current system is fragmented and doesn't promulgate successful models of team-based care. An academic practitioner envisions the future role of clinical psychologists and other mental health professionals like him as embedded in a primary care practice collaborating with the other primary care providers to provide comprehensive care to the patient.³¹*

V.9 Relative Payments to Family Physicians

The National Physician Database (NPDB) of the Canadian Institute for Health Information (CIHI) includes payments to family physicians by National Grouping System (NGS) strata.³² There are differences in the jurisdictional interpretation of counseling by family physicians, but no significant differences in the definition of psychotherapy. The 2009-2010 data release shows payments for psychotherapy/counseling and other strata, by family physicians, across jurisdictions, as follows:

P/T	Consultations	Major Assessments	Other Assessments	Hospital Care Days	Special Calls	Psychotherapy and Counseling
Payments in Thousands (\$000's)						
NL	10.4	1,393	57,845	2,572	2,113	1,857
PE	NR	NR	NR	NR	NR	NR
NS	1,127	3,253	103,397	10,273	2,733	3,712
NB	1,209	3,623	86,659	4,709	1,576	4,605
PQ	19,762	158,088	631,871	9,334	16,373	60,810
ON	17,544	189,949	913,173	62,319	178,390	174,132
MB	2,170	37,767	94,430	16,533	11,820	3,500
SK	1,575	15,682	107,412	9,013	4,528	8,899
AB	24,712	148,534	507,948	31,596	38,161	59,321
BC	10,651	290,924	350,258	31,392	60,817	39,476
YT	NR	NR	NR	NR	NR	NR
Total	78,759	849,212	2,852,993	177,741	316,509	356,311

It is noted that \$356M is paid to Canadian family physicians for psychotherapy and counseling services; this, despite the absence, for the vast majority, of significant training in psychotherapy or counseling and, when the demand on the time of family physicians is progressively high as the acuity of community population health indices increases, particularly in the management of chronic diseases and complex care patients.

Expressed as a percentage of total jurisdictional payments to family physicians for assessment services, the values are, as follows:

P/T	Consultations	Major Assessments	Other Assessments	Hospital Care Days	Special Calls	Psychotherapy and Counseling
Percentage of Total Jurisdictional Payments to Family Physicians for Assessment Services (%)						
NL	0.02	2.12	87.92	3.91	3.21	2.82
PE	NR	NR	NR	NR	NR	NR
NS	0.90	2.61	83.05	8.25	2.20	2.98
NB	1.18	3.54	84.64	4.60	1.54	4.50
PQ	2.20	17.64	70.50	1.04	1.83	6.79
ON	1.14	1.24	59.47	4.06	11.62	11.34
MB	1.31	22.72	56.81	9.95	7.11	2.11
SK	1.07	10.66	73.02	6.13	3.08	6.05
AB	3.05	18.33	62.69	3.90	4.71	7.32
BC	1.36	3.71	44.7	4.01	7.76	5.04
YT	NR	NR	NR	NR	NR	NR
Total	1.70	18.34	61.60	38.38	6.83	7.69

As a percentage of total jurisdictional payments to family physicians for assessment services, psychotherapy and counseling in Ontario is significantly greater than the national trend; Alberta approximates the national trend; the remaining provinces are lower than the national trend, especially Manitoba, Nova Scotia, and Newfoundland and Labrador.

Work is a reflection of (*time x intensity*), a formula applied frequently in studies of the relative value of physician services. In this context, intensity is a factor of:

- Knowledge and judgment
- Communication skills
- Risk and stress
- Communication skills

The following table, as a reflection of psychological services provided by family physicians (other than well-trained GP psychotherapists) and those provided by psychologists, weights the five variables of the value of work. These assessments are those of the consultants, who are experienced in weighting relativity in work measurement, and offer ranges to reflect differences among various typical patient populations and the psychological services required and provided.

Relativity in Measurement of Work (Psychological Services and Psychotherapy)

FAMILY PHYSICIAN	VALUE OF WORK	PSYCHOLOGISTS
20 - 50 minutes, typically 20	Time	20 - 50 minutes, typically 50
1 2 3 - 4 5 6 7	Knowledge and Judgment	1 2 3 4 5 - 6 - 7
1 2 3 4 - 5 6 7	Communication Skills	1 2 3 4 5 6 - 7
1 2 - 3 4 5 6 7	Risk and Stress	1 2 3 4 5 - 6 7
1 2 3 4 5 6 7	Technical Skills	1 2 3 4 5 6 7

V.10 Public Sector and Total Expenditures for Physicians and Other Health Professionals

The National Health Expenditure Database (NHEX) of CIHI includes public sector, private sector, and total expenditures for physicians and other professionals.

Canada does not have a comprehensive information system for mental health expenditure. This circumstance is not surprising, as responsibility for health care is diffused, with provincial governments assuming main responsibility and the federal government assuming responsibility for specific groups. Within provinces, responsibility for funding hospitals, physician services, and insured services by other professionals is often spread across different public sector agencies.

CIHI is the most comprehensive source of information on health services and expenditure in Canada. CIHI is able to identify hospital inpatient treatment for mental illness, and it has recently published a report showing provincial rates of treatment.³³ CIHI provides partial information on treatment by physicians in the form of utilization and expenditure for services of fee-for-service psychiatrists, and general practitioner (GP) services categorized as psychotherapy. GP psychotherapy services include psychotherapy and counseling, with definitions in provincial fee schedules that are sufficiently broad in scope to include visits in which there is an element of advice or lifestyle counseling.

NHEX provides information on expenditure for the following types of health care providers: physicians, dentists, eye care (including optometrists services and eyeglasses) and all other providers grouped together, in the following table.³⁴ An estimate of the amount of expenditure for other providers that would be accounted for by psychologists is provided in a later part of this section.

Estimated Expenditure for Health Care Professionals 2011

Type of Professional	Amount (\$ Millions)	Expenditure per Capita (\$)	Expenditure by Public Sector (%)
Physicians	27,398	802.84	98.9
Eye and Dental Care	17,296	504.48	5.9
Other Professionals	3,302	96.77	19.2
Total	47,916	1,404.09	60.0

The most comprehensive estimates of mental health expenditure in Canada were prepared in 2010 by Jacobs et al for the Mental Health Commission of Canada.³⁵ Their estimates for fiscal 2007-2008 totaled \$14.3 billion, of which \$10.6 billion was for services and \$3.7 billion was for income support. The authors acknowledge gaps in the data and did not attempt to estimate missing elements. Instead, their intention was to *fill as many data gaps as possible* under circumstances in which a systematic mental health perspective for measuring expenditures does not exist³⁶. Expenditures that could be identified were grouped into the following categories: hospital inpatient, physicians, pharmaceuticals, community and social services, other services (including non-profit organizations) and income support; these are demonstrated in the following table.

**Estimated Total Expenditure in Canada for Mental Health Services in Canada 2007-2008
(For Reporting Provinces and Services)**

Type of Expenditure	Amount (\$ Millions)
Hospital Inpatient	2,773.3
Physicians	1,427.1
Pharmaceuticals	2,814.9
Community & Social services	2,946.6
Other Services (non-profit organizations, education, housing and employee assistance plans)	657.0
Income Support (Public & Private)	3,728.7
Total	14,347.6

Health services consisted of the first three categories and portions of the community and social services category. Health services funded by the private sector included privately purchased drugs and services provided by non-profit organizations. Funding by workers' compensation boards and private health insurance firms (which are significant purchasers of services not insured by provincial plans) were limited to income support. The authors estimated that mental health accounted for 7.2% of public spending for health care in 2007-2008. As noted above, this percentage is likely less than the

actual percentage due to data gaps and difficulties in identifying the amount of expenditure for some health services that would be allocated to mental health (for example, emergency rooms and long term care services were not available for most provinces; physicians expenditure would include consults and other conventional treatments, such as unexplained medical symptoms and some pain management necessitated by mental health conditions and these services would not be reported as mental health care, except where the physician is a Psychiatrist).

A significant data gap was the absence of information on the costs of services paid by patients or private insurance for commodities other than prescription drugs. Most services by private practice psychologists are paid through out-of-pocket expenditure, private insurance or on a contract basis with public bodies such as workers' compensation boards. As a result, the cost of psychologists' services would be missing from the estimates by Jacobs et al, except where those services were provided in hospital or through community mental health agencies. Presumably, most psychologists providing services in these three venues would be employees of the respective organizations, rather than private practitioners.

Estimates of Expenditure for Private Practice Psychologists' Services

The CIHI estimate of \$3.302 billion for the services of Other Professionals in 2010 would include psychologists' services. Due to the structure of the CIHI health expenditure data model, most of the services in this category would be provided in private practice. Services by hospital psychologists, for example, would be categorized as hospital expenditures. Services by psychologists in the education system would be classified as educational spending rather than health spending.

In this section, we present estimates of expenditure for private practice psychologists' services by province. Data sources consist of surveys of psychological associations carried out as part of our consultations as well as a detailed membership survey of psychologists in Alberta carried out in 2010.³⁷ The authors developed the estimation methods; they are somewhat speculative but we believe they are broadly representative of the impact of private practice psychology on Canadian health expenditures.

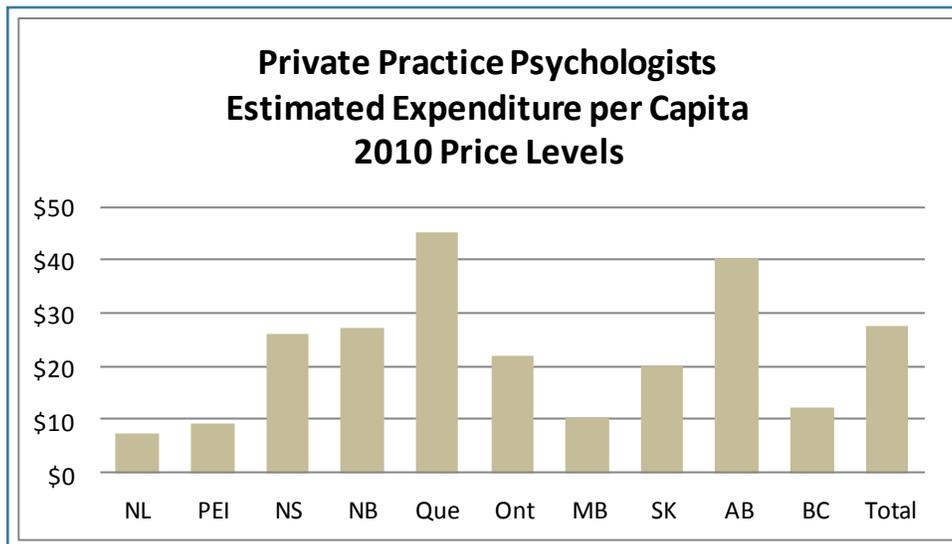
Two methods to estimate expenditure were used. The first was an estimate of gross professional income. The second was based on an estimate of the number of services billed per week and the effective rate per hour of service. Effective rates are normally less than rates posted in provincial fee schedules for a number of reasons, including reduced charges for some clients and hourly fees paid by public bodies that are often below fee schedule rates. The two methods produced estimates that varied by less than two percentage points in all provinces except Quebec, which provided estimates of the public sector hourly rate but did not provide a fee schedule rate.

The estimates based on gross professional income are used in the analysis that follows. The estimates use income data from 2010 and supply data from 2012. Consequently they represent current expenditure estimates at 2010 price levels. A more complete description of methodology is provided in a data appendix.

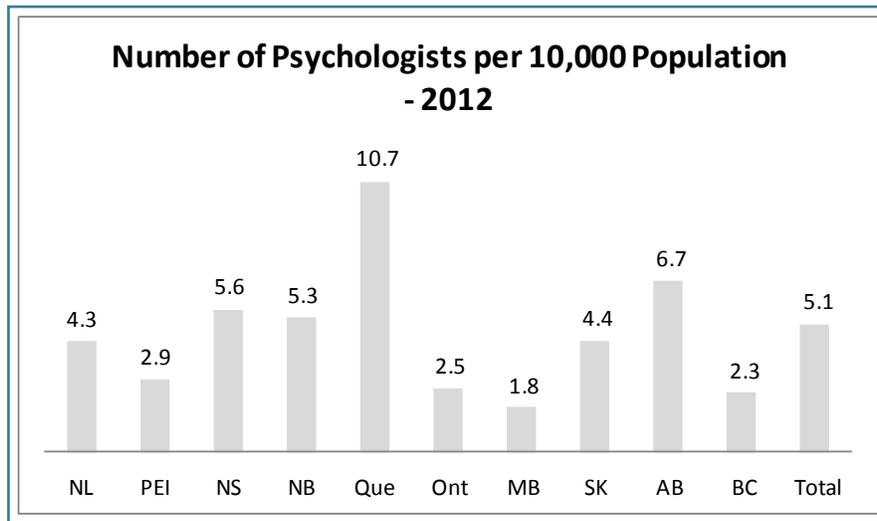
Estimates of expenditure for private practice psychologists' services in the ten provinces totaled approximately \$950 million and was equivalent to \$27.54 per capita. Quebec, Ontario and Alberta account for most expenditure with Quebec and Alberta having the highest expenditure per capita, demonstrated in the following table and figure. Expenditure per capita in Quebec is more than double, and expenditure per capita in Alberta is almost double, the median for all provinces.

Estimated Expenditure for Private Practice Psychologists Services by Province at 2010 Price Levels

Province	Expenditure (\$000)	Expenditure per Capita \$
NL	3,722	7.29
PE	1,354	9.28
NS	24,698	26.12
NB	20,582	27.24
PQ	361,992	45.36
ON	291,843	21.82
MB	12,946	10.35
SK	21,063	19.91
AB	152,138	40.26
BC	56,081	12.26
Total	946,420	27.54
Median 10 Provinces		20.87



Expenditure per capita tends to be directly related to the supply of psychologists in a province. Quebec and Alberta have the highest number of licensed psychologists per capita, demonstrated, as follows:

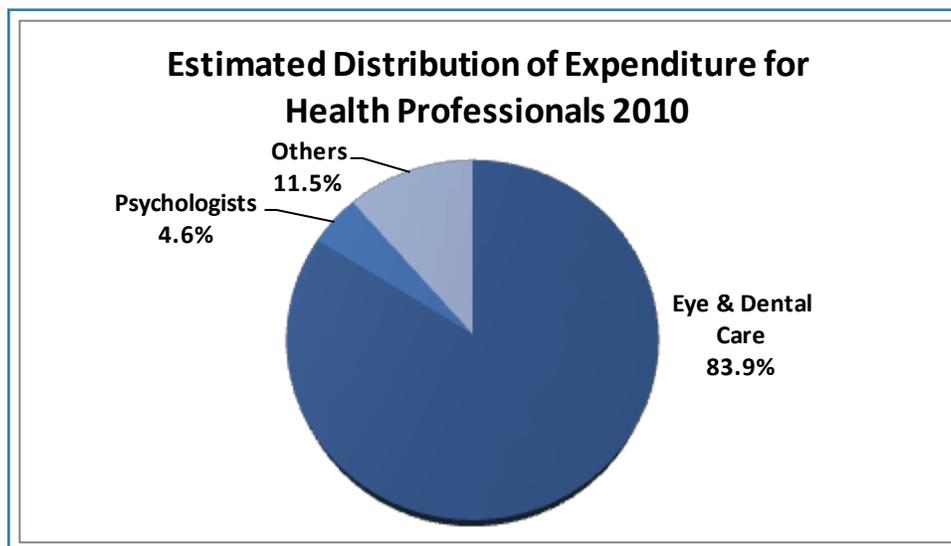


Private practice psychologists, on average, accounted for 40% of licensed psychologists. The numbers in private practice were estimated from data submitted by provincial associations: normally the variables used were funded mainly by private insurance and self-pay.

The actual numbers of full time and part time private practitioners are published by the Quebec Psychological Association;³⁸ Quebec estimates in this section were calculated using the number in full time private practice plus one-half the number in part time practice. In other provinces, private practitioners would be expected to include a mixture of those in full time private practice and those who are part time practitioners or who have part time salaried activities. Overall, estimates of private practitioners from Quebec, Ontario and Alberta appeared to be most reliable.³⁹ This is significant since those three provinces accounted for 85.9% of private practice psychologists and 85.2% of estimated expenditure.

Psychologists' Percentage of Total Expenditure for Health Care Providers other than Physicians

As mentioned earlier, the CIHI category of *Other Health Providers* is broken down to show eye and dental care and other professionals. The following figure, derived from CIHI and using estimates by the authors, demonstrates the effect of separating expenditure estimates for psychologists from the "others" category. Psychologists account for approximately 29% of the "others" estimate and 4.6% of total expenditure on health care providers other than physicians.



Psychologists' Percentage of Private Insurance Expenditure for Health Care Providers

Data from a large private insurer, which provides supplementary health insurance for approximately nine million persons across Canada, showed that payments for licensed psychologists' services in 2011 were \$28.5 million, which was equivalent to 1.1% of expenditure for all health care providers. The insurer indicated that most plans had annual limits on amounts paid per person.

Discussion of Current Expenditures

Expenditures for mental health care in Canada are not systematically reported. National health expenditure accounts are organized along two dimensions: types of service and source of funding, which do not provide a perspective on conditions treated, type of care (preventive, curative), and health outcomes. These characteristics are the result of the way the Canadian health care system is structured and the nature of administrative reporting systems. They are not likely to change in the near future. Consequently, analysts who wish to understand the magnitude of expenditure for mental health must use estimating techniques, including periodic data gathering projects and estimates compiled from available data.

The most comprehensive estimates of total expenditure for mental health services and supports were prepared for fiscal 2007-2008 and they contain notable gaps, especially with respect to ambulatory care and services funded through out-of-pocket expenditures and private insurance. These estimates totaled \$14.7 billion, which was equivalent to approximately 1.0% of GDP in 2007. Even if the actual expenditure were 50% higher, assuming all data gaps could be filled, the share of mental health expenditure in GDP would be only 1.4%. It is not wise to use expenditure as a proxy for the effectiveness of mental health care or to estimate unmet demand. Nonetheless, there are numerous studies (a small but relevant sample of which will be discussed in the next section) that document the prevalence and the economic cost of mental illness. These studies suggest that there is considerable unmet demand within both the publicly funded and the privately funded health systems, social

services, housing and other forms of support – all of which have the potential to improve mental health and realize considerable returns, both in terms of societal wellbeing and economic productivity.

In this section we have attempted to fill one gap in mental health expenditure estimates – the extent of expenditure for services provided by private practice psychologists. The results indicate that current expenditure at 2010 price levels for private practice psychologists' services is approximately \$950 million or \$27.54 per capita. The following points are worth noting:

- Although comparisons with other providers should be heavily qualified, it seems worth noting that expenditure per capita for private practice psychologists' services was equivalent to only 3.4% of expenditure per capita for physicians services (\$802 per capita in 2010); over 98% of physicians services are funded by the public sector.
- Psychologists' services expenditure was equivalent to 4.6% of total expenditure for services by all health professionals other than physicians.
- Almost all expenditure for private practice psychologists' services is funded by consumer out-of-pocket expenditure or by private health insurance. Exceptions would be contract services for public agencies such as workers compensation boards. Examples of public sector funding for full time psychologists, outside of hospitals and community service organizations, were at CLSCs in Quebec, which employ 680 psychologists, and a few primary care group practices in other provinces,⁴⁰ in addition to primary care services in Ontario and family health teams in Ontario.
- Private insurance expenditure for psychologists' services by one large group insurer, which is of sufficient size to be illustrative of the industry, amounts to 1.1% of its payments to all health professionals. This percentage is relatively small in comparison to the 4.6% share of psychologists in all funding sectors. Significantly, decisions about the terms under which psychologists' services are covered in the insurance package are made by employers. These data suggest that the preferences of employers, when purchasing employee health coverage, do not match preferences of consumers, who allocate a larger share of out-of-pocket health expenses to psychology.
- Psychology services tend to be carried out in 50-minute intervals, compared to approximately 15 minutes for physician services. While the longer time period allows a greater rapport and exploration of health issues between consumer and health professionals, it also imposes a significant cost on consumers (posted hourly fees across the provinces range from \$150 to \$220). These costs are difficult to finance for low-income persons, including those who may have lost employment and have an increased need for therapy. Expanded and reallocated public funding can be one source of relief.
- There is a large variation in expenditure per capita for private practice psychologists across the ten provinces. Expenditure per capita is highest in Quebec and Alberta where it tends to be double the ten-province median; these provinces also demonstrated higher than usual relative

payments to family physicians for psychotherapy and counseling, compared to other assessment services (as did Ontario and British Columbia).

- Expenditure per capita for private practice psychologists' services is directly related to the supply of psychologists. On average, about 40% of psychologists in most provinces are in private practice, either full time or with a significant part time commitment.
- Alberta and Quebec both have licensed psychologists who are Masters level graduates and this because of their tradition of registering at the masters level. Quebec has moved to registration at the doctoral level so the profile of psychologists in Quebec will change over time; Alberta has demonstrated liberal licensing laws.

Estimates of Cost Burden

There is a considerable literature on this subject and a convergence of estimates from numerous studies, which indicate that about 20% of the population has some form of mental health needs. The UK government literature often quotes a 25% lifetime incidence. A thorough review of the literature on the cost burden of mental health is beyond the scope of this project, which is focused on access to psychological services. The approach we have taken is to review three authoritative current studies that focus on the situation in Canada. These studies were carried out by the Mental Health Commission of Canada (MHCC), the Institute for Clinical Evaluative Services (ICES) and the Conference Board of Canada (CBC). The first study provides estimates for all of Canada whereas the other two focus on specific segments of the population or specific mental health conditions.

Mental Health Commission of Canada Report⁴¹

The report documents the facts that 20% of Canadians experience mental health problems or mental illness each year, but that only one-third of these people have sought and received treatment. In other words, the prevalence of untreated mental problems or illness may be as high as 14% in the Canadian population. The MHCC provides a succinct summary of the economic cost of mental health and the limitations of attempting to quantify cost in the following paragraph:

No studies to date have been able to calculate the full costs of mental illness incurred in the justice and education systems, the costs borne by family caregivers, or the costs of poor mental health to people who have not experienced the symptoms of illness. Nevertheless, it is clear that the total costs of mental health problems and illnesses to the Canadian economy are at least \$50 billion per year, and are likely significantly greater.⁴²

An analysis of the economic burden, drawing on a 2003 Canadian Community Health Survey and other sources, estimated economic burden within three categories.⁴³ The categories, and economic costs associated with each, are summarized in the following table. Valuations were made using conventional economic methods for calculating cost burden. In all cases the amounts shown are excess costs for persons with mental health problems relative to the population without mental health problems. The value of loss in health was calculated as the value of quality adjusted life years (QALY) lost through mental illness at a value of \$50,000 per QALY⁴⁴.

Economic Burden of Mental Illness in Canada, 2003

	Cost Burden (\$ millions)	Percent (%)
Direct Medical Cost	4,965	9.8
Short and Long Term Work Loss	17,729	34.8
Value of Loss in Health	28,153	55.4
Total	50,847	100

Source: Summarized from Lim et al, 2008, Table 2, pg. 95

These cost estimates could be increased by at least 2% per year since 2003 as the result of inflation. As a result, current costs in 2012 could be estimated as approximately \$60 billion per year, an amount equivalent to 3.4% of GDP. The comparison to GDP is used to indicate the magnitude of the economic burden relative to the size of the Canadian economy. The value of work loss and loss in health are not components of GDP, although reductions in work loss would be expected to result in corresponding increases in GDP.

The MHCC report also indicates that:

- Mental illness accounts for approximately 30% of disability claims
- The estimated lifetime economic cost of untreated childhood mental health disorders would be expected to be in the range of \$200 billion in Canada
- Preventing conduct disorders in one child through early intervention has been found to result in lifetime savings of \$280,000
- Improving a child's mental health from moderate to high has been found to result in lifetime savings of \$140,000

These points underline the importance and resource implications of prevention and early intervention. The Commission recommends increasing the share of health spending allocated to mental health by two percentage points - from an estimated 7% at present to 9%. CIHI estimates total health spending in 2011 as \$200.6 billion.⁴⁵ A two-percentage point reallocation to mental health would be valued at \$4 billion.

Conference Board of Canada Report⁴⁶

The Conference Board of Canada (CBC) issued a report in July 2012, with a view to estimating the economic burden of mental illness due to six specific conditions on labour force participation. The conditions studied were depression, dysthymia, bipolar disorder, social phobia, panic disorder, and agoraphobia, which the CBC identified as the most common conditions affecting working-age Canadians. The report estimates the current cost through lost labour force participation as \$20.7 billion and predicts that this cost will increase to \$29.1 billion by 2030.

The CBC estimates are somewhat higher than the estimates of the economic burden due to work loss, but given the difference in periods measured, they appear to be very consistent, taking into account inflation during the intervening period. The CBC report reinforces the conclusion that employers and society, as well as consumers, pay a heavy cost for mental illness that can be treated or alleviated by appropriate measures.

*Institute for Clinical Evaluative Sciences and Ontario Public Health*⁴⁷

This report examined the burden of mental illness in terms of deaths and loss of health attributable to nine conditions that are major causes of mental illness and for which relevant data were available. The conditions were major depression, alcohol use disorders, social phobia, bipolar disorder, schizophrenia, panic disorder, cocaine and prescription opioid misuse and agoraphobia. The study found that these conditions were responsible for 867 deaths, 20,283 years of life lost due to premature mortality (YYL) and 603,722 health adjusted life years lost (HALY) in Ontario during a typical year.⁴⁸

The study found that the burden of mental illness, in terms of premature mortality and ill health, was 1.5 times the burden of all cancers and 7 times the burden of infectious diseases. Depression caused the greatest health burden and, “The burden of depression alone is more than the combined burden of lung, colorectal, breast and prostate cancers”.⁴⁹ The report called for a review of strategies for prevention and treatment of mental illness and addiction with a view to achieving an effective collaboration among stakeholders to achieve a reduction in the incidence and health burden of these conditions.

VI Canadian Models and Access to Psychological Services

Supplementing the context of historical initiatives to support mental health care in Canada, this section reviews models of delivery of mental health services in the primary health care setting in Canada.

The literature references at least four models of mental health service provision in primary care. The New Zealand Health Technology Agency reviewed the existing international evidence about the structure and workforce configuration of effective models of health service provision in primary care setting. The assessment identified the four models, summarized in the following table.

Type	Definition
Staff training	Involves provision of knowledge and skills to primary care clinicians or other staff, for example, on improving prescribing; providing skills in psychological therapies; dissemination of information and guidelines; and providing intensive practice based education seminars
Consultation - liaison	This is a variant of the training model but involves mental health specialists entering into an ongoing educational relationship with primary care clinicians to enable them to care for individual patients. Referral to specialist care is needed in a small proportion of cases.
Collaborative care	Can involve aspects of both training and consultation - liaison but also includes the addition of new quasi-specialist staff (sometimes called case managers) that work with patients and liaise with primary care clinicians and specialists in order to improve quality of care. This model may also involve screening, education of patients, changes in practice routines and developments in information technology.
Replacement/referral	Primary responsibility for the management of the presenting problem is passed to a mental health specialist for the duration of treatment (often associated with psychological therapy)

After Bower and Gilbody, 2005

The technical brief found that collaborative care and its variants to be the most widely researched. It concluded that, while there was no clear conclusion on the most effective model of mental health care, there is indication that collaborative care is of benefit especially for older adults. It also found that collaborative care interventions delivered by multidisciplinary teams may also improve clinical outcomes in those with persistent or recurrent difficulties, but the results are ambiguous for those with minor depression.⁵⁰

The literature suggests that, in Canada, as in other industrialized countries, 80 per cent of the population consults a general practitioner/family physician annually; of this 80 per cent, between 30 and 40 per cent have significant psychological symptoms.⁵¹ Family physicians are said to be the first contact for the majority of persons in need of mental health services. *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.*⁵² A study of an integrated model of mental health care in the Hamilton-Wentworth area of Ontario examined the relationship between family physicians and mental health professionals. Each primary care practice has an on-site mental health counselor and a

visiting psychiatrist. The study reports that the counselors are registered nurses, psychologists, or people with university degrees in social work or diplomas in community work.⁵³ Family physicians were of the opinion that their ability to deliver appropriate mental health services would be enhanced by access to mental health professionals. The study found that family physicians had high levels of satisfaction with their work with the mental health teams and that it benefited their patients. *The more contact and communication there is between family physicians and mental health care providers the more continuity of care there is for patients, and this leads to better health outcomes.*⁵⁴

A study of collaboration between family physicians and psychologists in Eastern Ontario found that a significant number of family physicians were not clear about the competencies of psychologists and many could not distinguish between psychologists and psychotherapists. They, however, were of the opinion that, *psychologists' interventions would be useful for patients with mental and emotional disorders or personal difficulties, and 78 per cent thought these interventions might be beneficial in the context of some physical problems.*⁵⁵ The study also found that 75 per cent of the family physicians surveyed believed that integrating psychologists into primary care would improve the quality of services provided. The family physicians acknowledged that they did not receive sufficient training in medical school to address the mental health problems they are faced with. They also reported that they were reluctant to refer patients to psychologists because of the cost to the patients.

In Quebec, health and social service centres (HSSCs) bring together local community services, residential and long-term care centres and a hospital centre. It allows for the coordination of different services offered by different providers in a geographic area. According to Fleury et al. (2012), Reforms in Quebec sought to promote different models of primary care, psycho-services, and new collaborative care models intended to improve access and continuity.⁵⁶ The study determined that the mental health primary health care system in Quebec is composed of community-based agencies, private psychotherapy clinics, and a network of residential resources. It also reported that access to mental health services have waiting times, for example, of 40 days per patient after referral by a family physician. Urgent cases are seen in the emergency room. The survey of 60 GPs in Quebec found that for the majority of physicians, *a clinical setting positively influenced the propensity to support patients with mental disorders. The nature of remuneration in HSSCs and hospitals (salary and hourly fees) allowed GPs to spend more time with their patients*".⁵⁷ In addition, the researchers argue that HSSCs offer better access to diverse mental health resources and the opportunity for collaboration. The study examined factors that worked against access to mental health services. It found that there was a lack of psychologists in the public system. Collaboration and cooperation was improved when GPs and mental health professionals were in the same building. It was found, however, that when professionals were not present in the same building, information sharing and cooperation were not consistent.

In its 2011 fall edition, The Canadian Psychological Association Magazine, *PSYNOPSIS*, presents examples of models of mental health care and the role of psychologists in the delivery of services. It identifies a number of initiatives in different settings across Canada. An outpatient mental health program at the Ottawa Hospital, Civic Campus provides an example of collaboration between hospital services and community therapists for people with borderline personality disorder (BDP). Following a retreat in 2011, professionals in hospital and community setting *identified an urgent need*⁵⁸ for

collaboration to increase access to evidence-based therapy for persons with borderline personality disorder. The monitoring of the program is being developed but at this time the author suggests their clinical impression is that the program is, *not only effective at a symptom level for patients but at a system level in terms of an increased willingness of community therapists to treat patients with BDP.*

In 2012, Clark and Emberly described a model of *Mental Health Care for Children and Youth in Halifax*. The model of care is called the Choice and Partnership Approach (CAPS). CAPS is described by the authors as, *a collaborative model which places the young person and their family in the centre of care, brings together demand and capacity ideas and a new approach to clinical skills and job planning*. The approach is a patient management system which focuses on expanding community mental health services. Based on evidence, overnight services have been reduced in favour of day programs (www.progressmedia.ca). The Mental Health Addictions Program at the IWK Health Centre in Halifax with CAPS has included the active involvement of children, youth, and families with professionals in identifying the demand for mental health services. This is said to allow providers to better match their clinical capacity to demand for services (www.saltscapes.com).

The approach is credited with reducing waiting lists and waiting times. Sharon Clark, a psychologist who is the clinical leader of the IWK's Mental Health and Strategic Plan Implementation Team, states, *We have significantly reduced wait times and improved access to services. We understand our treatment needs better than we did before – after the initial contact with our service, 36 per cent of youth go on to need individual treatment sessions, 35 per cent receive therapeutic group treatments, and 14 per cent exit our system as well as treatment needs are met or they require services from other community based agencies.*

Another innovative mental health care service is the *Share Mental Health Care (SMHC)* service in Alberta. It is a consultation service in Calgary, that partners family physicians with mental health professionals, including psychologists, social workers, and psychiatrists.⁵⁹ In this service mental health professionals work with physicians in the primary health care setting. The program has main two objectives:

- i. Increasing family physicians' ability to identify and manage mental health concerns
- ii. Direct delivery of mental health services within the primary care setting

Physicians and mental health consultants are together for the shared care consultation sessions, and are partners in the provision of mental health care to the patient. Flessati reports that the shared care service was evaluated positively but the time commitment required by physicians was a deterrent to their wide participation. A second service, the Behavioural Health Consultant Service (BHCS), was developed in 2006, at the request of family physicians, to expand the Shared Care Service model in such a way that physicians are not required to attend consultation sessions. In this service the behavioural health consultant (BHC) is integrated into the physician's clinic. BHCs are mental health care providers from various disciplines working in family physician clinics as part of the primary health care team. In an integrated care model the BHCs address a variety of mental and behavioural health concerns with the goals of prevention, early identification, quick resolution and promotion of good mental health. Consultations are approximately 20 to 30 minutes in duration (www.scpcn.ca).

The programs have been evaluated with positive results which include satisfaction by patients because of more timely service provision and improved functioning. Physicians were also satisfied because of increased skills in identifying and managing mental health issues and in their increased access to community resources.

In 2012, Graff and colleagues discussed *New Models of Care for Psychology in Canada's Health Services*; they argue that psychological services in health care have expanded beyond traditional areas of mental health and are playing an increased role in chronic care and in standard cardiac care. Further, routine psychological screening of cardiac outpatients is beginning to become standard practice in Canada. It is suggested that . . . *the role of health psychologists in cardiac care is likely to expand as the benefits of psychological interventions for a variety of cardiac populations become apparent*. The article discusses psychological interventions in insomnia treatment and psychological care before surgery. With reference to psychologists in family medicine practice, the Winnipeg Regional Health Authority (WRHA) provides examples of two models of integrated psychology and primary care services. Collaboration between psychiatrists and family physicians was established in 2009. Psychological services were added, subsequently, to the program. The psychologist provides consultation and support to the whole program. As well, the psychologist provides some direct patient care, but the key role is system-focused. In the second model, the psychologist provides direct patient care in a family medicine training clinic. The role of the psychologist includes diagnostic assessments, treatment, and resident and staff education. These services are intended to result in more timely and appropriate referrals of mental health cases.

These representative examples of relevant literature indicate that there is an increased movement in Canada toward collaborative community-based mental health services. Family physicians that have access to mental health professionals recognize the important contribution that they make as part of the mental health team. Psychologists in the public health system are in short supply. In the majority of the models discussed above psychologists provide training and/or consultation services to family physicians. A number of the models emphasize the benefits of a greater role for patients and families in the delivery of mental health services.

VII Special Needs Populations

VII.1 The Elderly

Currently, approximately 13 per cent of the Canadian population is 65 years of age or older. It is expected that by the year 2016, 16 per cent of the population, six million seniors, will be living in Canada. A 2010 Statistics Canada report predicted that, by 2036, one out of every four Canadians will be a senior. Many reports and studies have found that as much as twenty per cent of seniors are living with mental illness.⁶⁰ The Mental Health Commission of Canada 2012 report, *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada*, identifies four distinct populations living with mental illness in later life:

- i. Those growing older with a recurrent, persistent or chronic mental illness
- ii. Those experiencing late onset mental illness
- iii. Those living with behavioral and psychological symptoms associated with Alzheimer's disease and related dementias, and
- iv. Those living with chronic medical problems with known correlations with mental illness

These populations are also more likely to have co-morbidities. As an example of this, in 2010, Robinson & Spalle Ha suggest that major depression occurs in about 40 per cent of patients who have experienced an acute stroke. Depression is said to be the most common mental health problem for older adults and the rates are higher in long-term care homes, with up to 44 per cent of residents having an established diagnosis of depression.⁶¹ The Canadian Senate Committee on Social Affairs, Science and Technology reported in *Out of the Shadows at Last*, in 2006, that 80 to 90 per cent of seniors in nursing homes are afflicted with a mental illness or cognitive impairment. The resources to deliver necessary mental health services to this population are less than adequate.

The most common mental illnesses in older adults are mood disorders, cognitive and mental disorders due to a medical condition including dementia, delirium and substance misuse and psychotic disorder. Data also suggests that family physicians are experiencing an increasing number of consultations for mental health problems in elderly populations, more than consultations by younger adults and by children. There are different progressive degenerative illnesses of the brain, which are types of dementia. Alzheimer's disease is the most common type and according to the Alzheimer Society of Canada and accounts for 64 per cent of all dementias. As the population ages, the rate of Alzheimer's disease in the older population increases: 7 per cent at age 60, 20 per cent at age 80 and 85 per cent at age 85. The 2012 Mental Health Commission of Canada report states that the behavioral and psychological symptoms (BPSD) are the most challenging for the person and the care givers, affecting up to 90 % of persons with dementia over the course of their illness. Consequently mental health services need to be available particularly to assist in the management of BPSD. It is also important that mental health providers are able to differentiate between mild cognitive impairment and early dementia, and between dementia and depression. The health care providers must be appropriately trained to recognize, diagnose, refer or provide necessary services.

A 2005 report of the Government of Newfoundland and Labrador is consistent with other reports, such as that of the referenced senate committee, which argue that current service delivery models do not reflect the complex and changing mental health needs of the older population. It is often the family physician that sees the older individual experiencing mental health problems and is responsible for beginning the process of care which may involve other providers and or supports for the client or for the family care givers.

There is general agreement that ageism and stigma remain important factors in access to mental health services. Greater independence of older adults and improvement of their quality of life is promoted by: supported housing options, home care not dependent on physical disability, bereavement counseling, and day programs. It is suggested that mental health services for the older population could have the following:

- A strong health and social service system that is grounded in the recovery⁶² (principle) philosophy and guided by principles and values
- A mental health promotion which drives all aspects of the continuum, and
- An integrated mental health service system

Hollander argued, in 2010, that an integrated mental health service system for older adults would have a number of core components:

- Service providers skilled in early detection of mental illness in later life, including dementia
- Consultation and collaboration among providers as needed and,
- Consultation with psychiatric and mental health clinicians

Integrated mental health services for older adults includes counseling services which are usually provided by registered mental health professionals such as a psychologist, psychiatric/mental health nurse, social worker or occupational therapist.

The Canadian Coalition for Seniors Mental Health (CCSMH), in its presentation to the Committee chaired by Senator Kirby, stated that the treatment of depression is often addressed by pharmacological treatment, rather than psychotherapy treatment. It called for more emphasis on psychotherapeutic therapies such as behavioral therapy, cognitive behavioral therapy, brief dynamic therapy, and reminiscence therapy. The CCSMH reports that seniors tend to prefer psychological to pharmacological care. It also calls for an inclusive community-based system of recovery dedicated to assuring the social relevance of mentally ill seniors and the reduction of stigma.

The Ministry of Health and Long-Term Care of Ontario (2010) in a 2010 report, *Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy*, proposed the following: *Mental health and addiction services should, in turn, be integrated with other health care services – particularly primary care services and hospital services. Better coordination across the health system would help reduce avoidable emergency room visits as well as the current long waits for some mental health and addiction services. It would also keep people from being discharged from emergency without appropriate*

community supports. *Specialized mental health and addiction services should be provided by teams with the right mix of skills based on the person's and family's needs and aspirations.*

It is argued that an integrated mental health service system for older adults may vary according to local context and available resources. Integrated services should provide access to community based support services, primary care services, general mental health services and specialized seniors mental health services.

VII.2 First Nations, Métis, and Inuit Peoples

The health status of Aboriginal Peoples is much worse than that of the rest of the Canadian population. First Nation and Inuit Peoples live five to ten years less than other Canadians. The 2005 report of the Government of Newfoundland and Labrador, *Working Together for Mental Health*, states that, *infant mortality rates of Aboriginal Peoples are well above the Canadian norm and [they] experience premature death from injuries at a rate four times that of the Canadian population as a whole.* They also report high incidence of suicide, substance abuse, fetal alcohol spectrum disorders, violence and family and band breakdowns. Many reports have documented the health status, determinants and contributing factor of poor physical and mental health of First Nations, Métis and Inuit Peoples. Colonization, residential school, and other policies are said to have had a devastating impact on Aboriginal people.⁶³ Aboriginal peoples have poorer health outcomes, such as greater rates of depression, anxiety, substance abuse, and suicide rates that are many times greater than the rates of the general population. Studies have found that they are more likely to seek help for mental health problems than other Canadians, at 17 per cent compared to 8 per cent. First Nations people have been found to experience major depression at twice the national average. Suicide rates among Inuit are high at six to eleven times the Canadian average. In Nunavut for example, 27 per cent of all deaths since 1999 have been suicides.⁶⁴

The Aboriginal population in 2006 was more than one million, or 3.8 per cent of the total population of Canada. The majority of Aboriginal persons (60 per cent) identified as First Nations people, with 33 per cent as Metis and 4 per cent as Inuit.⁶⁵ While they are distinct cultural groups it is generally agreed that they share a common understanding of wellbeing or wellness as, *something that comes from a balance of body, mind, emotion, and spirit, is embedded in culture and tied to the land with a strong belief in family community, and self-determination.*⁶⁶

Understanding this view of wellness is critical to the success of programs to address them. Mental health care and substance abuse treatment programs should be culturally appropriate and responsive to Aboriginal communities. The Senate Committee heard presentations from witnesses who stressed the importance of designing responses that take the specific needs of the different population groups into consideration. The Senate Committee also stressed the importance of Aboriginal Communities being involved in the design and delivery of mental health services. There is a movement from mental illness to mental wellness and the approach that is being advocated is comprehensive and holistic and addresses the determinants of health.

The Vancouver Coastal Health, *Aboriginal Health & Well Plan 2008 - 2011*, presents five strategic priorities for the improvement of Aboriginal health and wellness. The first priority is to, *improve and better coordinate mental health and addictions services.* The Plan also calls for increased cultural

competency and responsiveness of the Health Authority staff to Aboriginal clients' health care needs and to support the inclusion of Aboriginal perspectives and lived experiences within the organization'. In 2009, the Mental Health Commission of Canada reported there are good examples of indigenous-led programs that draw on the importance of cultural identity and self-determination.

Reports suggest that there is a shortage of mental health professionals and, especially, of providers who are trained appropriately to work with Aboriginal Communities. It has also been argued that there is a critical shortage of adequately trained Aboriginal mental health and addictions professionals.

VIII International Models and Access to Psychological Services

VIII.1 United Kingdom

The United Kingdom has introduced two major initiatives to improve mental health during the last six years. The first, known as *Improved Access to Psychological Therapies (IAPT)*, is a structured program designed to increase access to behavioural therapy through the use of psychological therapists trained to deliver services within a team approach. The second, known as *No Health Without Mental Health*, is designed to improve public services for people with mental health problems, with its scope including the underlying causes of mental ill health. Each of the two programs is described below, followed by an analysis of experience.

Improved Access to Psychological Therapies (IAPT)

The IAPT program was developed in response to unmet needs for mental health care identified in a 2006 report by the London School of Economics, led by Professor Lord Richard Layard.⁶⁷ The report reviewed evidence of the prevalence of anxiety and depression and concluded that these conditions could be effectively treated at a cost of approximately £750 per person. A central conclusion of the report was that effective treatments exist which could cure one-half of those who suffer from these conditions. The therapies are *short, forward-looking treatments that enable people to challenge their negative thinking and build on the positive side of their personalities and situations. The most developed of these therapies is cognitive behavior therapy (CBT). The official guidelines from the National Institute for Clinical Excellence (NICE) say these treatments should be available to all people with depression or anxiety disorders or schizophrenia, unless the problem is very mild or recent.* The report concluded that treatments according to the NICE guidelines could be provided by an expanded workforce of specially trained psychological therapists and that a program to provide these services would produce major benefits for the population and the efficiency of the UK workforce.

The UK government launched the IAPT program in 2008. It was developed by a national IAPT Program Board, which continues to provide guidance. The program is implemented regionally by strategic health agencies (SHA) and primary care trusts (PCT), which are National Health Service (NHS) administrative groups responsible for the provision of health services in specific areas across the UK. IAPT program characteristics are summarized in the following box, drawing on a 2008 implementation plan.⁶⁸ The program's objective is to treat 900,000 persons with mild depression or anxiety per year by 2015 and to achieve a 50% rate of recovery. The program aims is to train 6,000 therapists in CBT by 2015. The new therapists will augment an existing workforce of 2,000 therapists. Dr. David M. Clark, who was one of the initial proponents of the program and presently serves as its Clinical Adviser, describes the program as *one of the world's largest attempts to disseminate CBT to the general public.*⁶⁹ Dr. Clark reports that over 450,000 persons are presently receiving IAPT services.

IAPT Program Characteristics

Conditions Treated

Depression and Anxiety Disorders

Delivery Models

- Teams of specially trained psychological therapists
- PCTs are responsible contracting or providing services
- Patients are referred by GPs or self-referral
- Teams of therapists are led by a senior therapist and consist of therapists trained in high-intensity and low intensity therapy
- Teams may be supported by a GP advisor, an employment advisor, and administrative staff
- Services are to be provided in GP practices, employment centres, or on the premises of voluntary organizations
- A system of stepped care is recommended for depression. Most people with mild to moderate depression begin with low-intensity treatment, which may take the form of watchful waiting, guided self-help, or guided use of computerized CBT
- The next step, for persons who are severely depressed or do not respond to low-intensity treatment, consists of high-intensity treatment involving up to 20 therapy sessions, normally on a face-to-face basis
- High-intensity treatment is also recommended for severe persistent anxiety disorders (post-traumatic stress, obsessive-compulsive disorders, generalized anxiety disorder, and panic disorder)

Workforce Specifications (Excerpts from items 4.25 and 2.26 of the Implementation Plan)

- A target ratio of 40 teams to serve a population of 250,000
- Trainees in high-intensity therapy are likely to be drawn from the professions of clinical psychology and psychotherapy, as well as people with experience with mental health in other capacities, such as nurses, counselors, and other professional groups
- Low-intensity therapists will need a one-year course that involves one day per week, off-site, together with supervised work handling cases in IAPT services; these trainees are likely to be drawn from wider sources; it is recommended that they consist of people with relevant life and work experience, as well as psychology graduates

Source: Improving Access to Psychological Therapies Implementation Plan

Funding

The UK provides detailed reports of funding in its National Surveys of Investment in Mental Health.⁷⁰ The surveys cover the working age population (ages 18 – 64) and the elderly. Estimated expenditure on mental health and expenditure per capita for each of these groups in 2011/12 are shown in the following table.

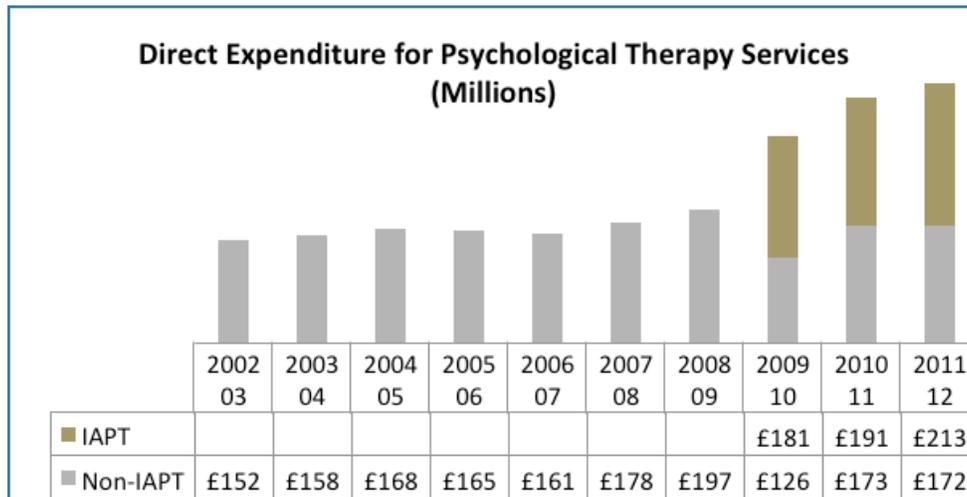
UK Expenditure on Mental Health 2011/12

	Working Age Adults	Elderly
Total Expenditure (Millions)	£6,629	£2,859
Expenditure per Capita	£198.3	£341.2

Source: UK DH Investment in Mental Health Reports

The reported expenditures include direct expenditure on services (benefits), overhead costs and capital expenditures.⁷¹ Expenditures on services accounted for approximately 83% of expenditures for adults and 85% of expenditures for the elderly. Data reported below for psychological therapy services focus on expenditure for services and do not include overheads or capital, which are only reported for aggregate mental health expenditure.

Expenditure for psychological therapy services are shown in the following figure for the period from fiscal 2002/03 to 2011/12. Prior years data have been adjusted for inflation in order to show real expenditure changes at 2011/12 price levels. The services include both IAPT and non-IAPT services. Expenditure for IAPT is shown explicitly beginning in 2009/10. Presumably, some of the 2008/09 expenditure labeled “non-IAPT” would include expenditure for IAPT as the program was introduced during the fall of that year. The trend shows substantial increases in expenditure for IAPT during the last three years. Non-IAPT expenditure declined in 2009/10 and then leveled out during the next two years at approximately the same amount as was spent in 2007/08. This trend suggests that there was a modest replacement effect, with IAPT services replacing some services that were provided prior to the reduction of IAPT.

Expenditure for Psychological Therapy Services in the UK Adult Population 2002/03 to 2011/12

Expenditure estimates for the elderly population do not include psychological therapy services. Approximately 95% of total expenditure for the elderly consisted of: residential care in the community; inpatient care & integrated mental health teams; home care and day services.⁷²

Over 99% of psychological therapy services were commissioned by PCTs, which are responsible for most NHS expenditures at local levels. The remaining services were commissioned by local authorities. NHS providers were also the dominant providers of psychological therapy services, as shown in the following table.

**Expenditure for UK Psychological Therapy Services by Type of Provider: 2011/12
(£000)**

	NHS	NGMS	Non-Statutory	Social Services	Total	Percent NHS
IAPT	160,086	3,600	48,049	1,629	213,364	75.0%
Non IAPT	139,334	6,235	26,574	101	172,244	80.9%

Legend:

NHS - NHS Trusts, Care Trusts and Directly Providing PCTs

NGMS - services delivered by the General Medical services but funded from mainstream PCT resource allocations

Non Statutory Providers - private providers, voluntary or charitable organizations

Social Services - delivered directly by Local Authorities

Source: National Survey of Investment in Adult Mental Health Services 2011/12. Appendix 7

Expenditure per capita for psychological therapy (IAPT plus non-IAPT) was approximately £11.53 based on a working age population of 33.4 million. While this amount may seem relatively modest, it should be viewed in the overall context of a suite of services that includes inpatient, ambulatory and home based services.⁷³ As noted in Table 1, total spending per capita for mental health care in the adult population was £198.3. These per capita amounts would be equivalent to approximately \$18 and \$307, respectively, in Canadian currency during 2010/11.⁷⁴

It is also important to realize that the total investment in mental health services reported in the adult investment report does not include most medical care by physicians and hospitals funded through the NHS. The amounts included in the investment reports are for services commissioned at local level for mental health programs.⁷⁵ A recent report from the London School of Economics, discussed in the evaluation section below, documents £14 billion in expenditure for mental health care provided through the NHS. There seems to be a possibility of some overlap between the amounts reported there and the expenditures reported in the investment reports; but given the challenges of reconciling data from different information systems and the inherent limitations of an analysis of spending through a literature review, it is not possible to reconcile any such amounts.

As mentioned above, mental health services expenditure for seniors is heavily concentrated in institutional care (residential care and inpatient) and in home services. The IAPT program was originally introduced for people of working age but was expanded to include adults of all ages in 2010. The Department of Health recently announced that an IAPT plan for children will be introduced over the next three years and is expected to be fully operational by April 2015. A budget of £54 million has been allocated to finance the roll out of the children's IAPT program. In addition, the Department of Health states that; 'models of care for people with long-term physical conditions, medically unexplained symptoms and severe mental illness will be developed.'^{76,77}

The completion of the IAPT roll out will also feature a greater focus on seniors over 65.⁷⁸ Seniors represented only 4% of IAPT clients in past but are expected to use up to 12% of services when the IAPT expansion is completed.⁷⁹ The IAPT workforce training program will be expanded to include participation by senior care groups as well as continuing education programs for general practitioners and other professionals employed in related care areas. Employment support, which has been determined to be an important adjunct to CBT, will be expanded. Plans call for one employment support worker for every eight therapists by 2013/14. In future, IAPT funding responsibility will be transferred from the national government to the base budget allocations of primary care trusts.

IAPT program accomplishments are summarized in the following box.⁸⁰

Summary of IAPT Accomplishments

- 142 of the 151 Primary Care Trusts in England had established an IAPT service
- Over 50% of the adult population had access to IAPT services
- 3,660 new cognitive behavioural therapy workers had been trained
- Over 600,000 people started treatment; over 350,000 completed it
- Over 120,000 moved to recovery and over 23,000 came off sick pay or benefits (between October 2008 and March 2011)
- Savings from the IAPT program, when fully implemented in 2015, are estimated to be valued at £272 million for the NHS and £700 million for the entire public sector

Source: IAPT web site

Evaluation

The IAPT program design has been studied, both from a clinical perspective and evaluation of results. Denman (2007) provides an excellent discussion of clinical issues.⁸¹ He points out that there is an inherent tension between a program that is designed to treat persons who have specific disorders with defined protocols and the techniques of the larger professional milieu within which it operates – a milieu that values personal insight by highly trained professionals and a range of therapies often based on nuanced relationships between patient and therapist. The circumstances in which care is delivered at the local level are also important considerations in the effectiveness of therapy, and these circumstances vary across the local institutions that provide care.

A 2010 study by Richards and Borglin assessed results for over 4,000 persons in one IAPT service over a two-year period.⁸² They found that persons using the service received a mean of 5.5 services, mainly in the low intensity category. Statistically significant recovery rates for anxiety and depression were found, at 40% and 46% respectively. On the negative side, 47% of referrals to the service did not report for an assessment or did not proceed from assessment to treatment.

A 2010 report by the *We Need to Talk Coalition*, a group of mental health charities led by *Mind*, and associations representing health care professionals and other stakeholders, analyzed the implementation and coverage of IAPT across local jurisdictions responsible for service delivery.⁸³ The report was drawn from a 2010 study that included a survey of persons who had attempted to access psychology services in the previous two years (527 responses) and interviews with local branches of the *Mind* organization and health care providers. Examples of exemplary care under the IAPT plan were found in some local areas, such as, *In these places, waiting times have been cut drastically, recovery rates are good, people are returning to work and satisfaction is high among people using the services.* (p. 12)

On the other hand, the report maintains that some local authorities have implemented IAPT in ways that actually reduce access to psychological therapy. Specific concerns include: (1) long waiting times – one in five IAPT eligible persons surveyed had been waiting for one year and one in ten had been

waiting for 2 years to receive treatment. (2) Lack of choice – half of those surveyed had a choice in the time of their therapy sessions, 13% had a choice in where they received therapy and only 8% had a full choice with regard to the type of therapy they receive. (3) Universal access, with less than two-thirds of those with severe mental conditions receiving therapy and disparities in access that worked to the disadvantage of children, men and minority groups. The study also found that some local authorities had used IAPT to replace other psychology services, even though the funding for IAPT was meant to be exclusive to that program and its overall goal was to increase access for mild to severe conditions, freeing up previously existing resources for persons with more severe needs.

The coalition issued several recommendations, including a cross-cutting recommendation that the NHS ensure that, in future, *People should be given a full and informed choice when accessing psychological therapies. This should include choice around therapy type, therapist, appointment times and location of treatment.*

A 2012 report by the London School of Economics is critical of the current resource commitment to mental health.⁸⁴ It maintains that some of the local agencies are not using IAPT funds for their designated purpose and are not staffing up to required levels: *In the first three years, 3,600 therapists were trained, leaving a planned 800 a year for 2011/12 and each succeeding year. However the number trained in 2011/12 was only 525, with almost no trainees at all in two major regions of the country* (p. 15).

The report documents NHS spending of approximately £14 billion annually on primary and secondary treatment of mental health conditions (p. 10) and estimates that at least £10 billion is spent on additional physical care related to mental health problems. The authors quote the opinion of an expert panel that, . . . *much of this money [the £10 billion] would be better spent on psychological therapies for those people who have mental health problems on top of their physical symptoms* (p. 1). The report argues for enhancement of funding for IAPT. It expresses concern that the program to provide IAPT for young people, which was introduced in 2011, is presently experiencing a reduction in funding.

No Health Without Mental Health

In 2011 the U.K. government published a strategy for mental health services known as *No Health Without Mental Health*.⁸⁵ The strategy is designed to improve public services for people with mental health problems, with its scope including the underlying causes of mental ill health. The strategy relies on an approach that focuses attention on interventions at local levels, driven primarily by initiatives of communities and individuals. This approach of the current U.K. government is known as the 'Big Society'. Consistent with this approach the No Health Without Mental Health Initiative stresses actions by local authorities, employers, charitable organizations and mental health consumers themselves.

The report cites estimates that the annual cost to employers of work losses due to mental health exceeds £1,000 per employee and the total economic cost of mental health to the UK approximates £105 billion. It estimates that treatment costs for mental health conditions will double within the next 20 years. The government's financial commitment to the program is £400 million during the next four years. These funds are meant to finance the final stages of the rollout of the IAPT initiative to 2015, as discussed above.

The strategy calls for a reorientation of services, with a view to, . . . *shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises* (p.67). The strategy will include activities by several ministries and the non-government sector. Planning activities have been underway during 2011 and 2012. In July, 2012, the Department of Health published an implementation framework document, which describes activities that can be undertaken at local levels and summarizes activities underway at the national level.⁸⁶ The framework was prepared by a working group that included major stakeholders from national mental health support groups as well as civil society organizations.⁸⁷ The report reviews achievements in IAPT and other mental health programs. It promises to modify payment systems to provide higher payments to mental health providers that demonstrate higher quality. It also promises to *...put mental health and wellbeing at the heart of the new public health system* (p. 2).

The implementation framework describes activities by local groups, including health care commissioning groups (e.g., PCTs); health care providers (mental health, primary care, community and acute care); volunteer and user-led community groups; schools and colleges; employment support organizations; employers; the criminal justice system; and housing support groups, including maintenance and infrastructure support for independent living.

The framework concludes with a section on activities by national government and government agencies. The section also includes national mental health organizations and charities. This section is quite explicit about the roles and activities of each organization. This approach is expected to define a set of goals and activities that will allow progress to be monitored as the program matures.

Discussion of Initiatives in the United Kingdom

The IAPT program is a large scale project to address the need for psychological therapy to deal with anxiety and depression, which have been identified as major mental health problems in the UK, leading to a large loss of productivity and avoidable distress for an estimated 20% of the population. The IAPT strategy is funded and led by the national government but implemented at local levels. It is integrated with other community mental health activities at those levels. Most IAPT provider groups are affiliated with the NHS, leading to close associations between psychological therapies and medical care.

At the outset of the IAPT program, a need for trained therapists was identified as a major challenge. The program undertook to train 6,000 therapists, who were expected to join 2,000 existing therapists to form a workforce of 8,000 persons trained in CBT for anxiety and depression. The workforce is structured in two tiers - low intensity and high intensity services. Therapists work in teams led by a person with senior qualifications and comprising therapists trained in both low and high intensity therapy. Clients are either referred by GPs or self referred. Usually they enter treatment at low intensity therapy; those who do not respond or who enter therapy with severe levels of distress are treated with high intensity therapy.

The program has been rolled out in a structured way, beginning with demonstration sites and being expanded across local health regions. While initially targeted to the working age population, its scope was expanded to include all ages in 2010. At present an IAPT program is being implemented for children and young people, recognizing the special needs of this group.

A process for structured evaluation was not built into the program but instead a number of targets, or indicators, were established and a robust reporting system was put in place to monitor progress. UK health systems operate with 'outcomes frameworks', which provide criteria for setting goals and measuring accomplishments. In the case of mental health, outcome frameworks exist for the NHS, Public Health, and Adult Social Care.

Experience to date with the IAPT program has been positive, with its goal of 50% of persons in treatment progressing to recovery close to realization. Concerns have been identified about issues such as waiting times and choice of therapy or location of service. The groups that have identified these issues, largely provider groups and mental health charities, are involved in planning the future expansion of IAPT and, hopefully, their studies to date will have a positive influence in terms of addressing weaknesses in the present system. Concerns have also been raised about the commitment of local agencies to meeting goals for funding and training (i.e. the LSE report).

The UK government has announced a commitment of £400 million to complete the roll out and expansion of IAPT by 2015. It has made this commitment within the scope of the No Health Without Mental Health program, which seeks to increase the involvement of government at national and local levels, provider groups, stakeholders and civil society in a large scale effort to improve mental health in order to realize the substantial gains in productivity and wellbeing that can be achieved in doing so.

The UK is in a somewhat unique position to measure financial resources provided in community mental health programs as well as in the NHS. The costs of IAPT in its initial years have been influenced by training costs as well as delivery costs. As a result, it is difficult to measure ongoing costs of a mature program. Nonetheless, the 2011-12 cost of £11.53 per working age adult seems modest, especially in light of outcomes reported. The model of public funding and delivery is consistent with the organization of the UK health system, especially the NHS. This system is presently experiencing a period of transition as a result of policies of the new government. Indeed, the NHS system itself has been subject to considerable change and reform during the last two decades (e.g., the internal market concept under which primary care providers, or trusts, become responsible for purchasing a broad range of services on behalf of their clients⁸⁸). The integration of IAPT with the overall system of health delivery should insure that the program benefits from any efficiencies realized in the transition process, or allow it to benefit from corrective actions if deficiencies are encountered.

VIII.2 Australia

Australia provides mental health services through federal and state government facilities, private hospitals, subsidized community services, reimbursement of professional services through the Australian Medicare Benefit Schedule (MBS) and subsidies for prescription drugs paid through the Pharmaceutical Benefit Schedule (PBS). In 2011, Australia published the first of a series of

comprehensive reports on mental health services.⁸⁹ The report estimates that 45% of Australians will experience a mental health problem during their lifetime and that 20% of those between 16 and 85 suffer from mental health problems in any given year. Australian expenditure on mental health in 2008-09 by all levels of government and private insurance funds was estimated to exceed \$5.8 billion, equivalent to \$272 per capita.⁹⁰ The Australian federal government expenditure was approximately \$2.2 billion, with \$1.4 billion representing subsidies from the MBS and PBS.

Better Access to Mental Health Care Initiative

Australia introduced a program known as the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative* in 2006 as a component of the Council of Australian Governments' National action plan on mental health 2006-2011.⁹¹ Under this program, persons with diagnosed mental health disorders can receive specific insured services from general practitioners, consulting psychiatrists, private practice psychologists, occupational therapists and social workers. These services are paid through the MBS.

In order to receive services, patients must be referred by a general practitioner, pediatrician or psychiatrist, who is required to complete referral documentation that includes a treatment plan. Benefits include up to 10 individual therapy or group therapy sessions during a year. Eligible providers may be paid directly by Medicare at established fee-for-service rates (known as 'bulk billing') or they may charge patients according to their own fee schedules, in which case patients pay for the services and claim reimbursement at insured rates from Medicare. Patients may choose to claim reimbursement through private insurance, but cannot use private insurance to top up government reimbursement. One conclusion of this study is that family physicians should not be gatekeepers to access to psychologists' services and that referral requirements are not appropriate.

The purpose of the Better Access Plan is 'to improve treatment and management of mental illness within the community.'⁹² The program also addresses issues in the delivery of mental health care by encouraging collaboration between general practitioners, psychiatrists, psychologists and appropriately trained social workers and occupational therapists. The Australian government has stated that: 'Better Access was neither designed nor intended to provide intensive, ongoing therapy for people with severe and persistent mental illness.'⁹³ This policy has been cited as a rationale for reducing the annual service limit from 12 to 10 services in November 2011 (these changes to annual limits are discussed below). Better Access funding is provided in the form of reimbursement of insured services through the (MBS) and educational programs for mental health care providers.

Psychologists participating in the Better Access plan must be registered with the Psychology Board of Australia (PBA) and have a Medicare provider number. The MBS distinguishes between clinical psychologists and other registered psychologists. Clinical psychologists are registered psychologists who are qualified to use the title 'clinical psychologist' as defined by the PBA.⁹⁴ These qualifications include membership in the APA College of Clinical Psychologists, which requires 4 years of study in psychology and an accredited doctorate degree in clinical psychology or a master's degree in clinical psychology with one year of supervised post-masters clinical psychology experience.⁹⁵ Clinical psychologists may claim a group of services known as psychological therapy. A second group of

services, known as focused psychological strategies, may be claimed by other registered psychologists, occupational therapists and social workers.

Psychologists are required to submit a written report to the referring physician after the first 6 visits following a referral, at which time the referring physician may authorize an additional 4 services in that calendar year. Psychologists may continue to treat the patient as long as s/he continues to be a patient of the referring physician under the physician's mental health treatment plan. The annual limit of 10 services may be augmented up to an additional 6 services in exceptional circumstances, in which case the referring doctor must make out a new referral. The higher limit is a provision of the 'transition plan' for 2012 and not meant to be a part of the program after year end. These annual service limits were announced as part of a series of changes to the plan in November 2011.⁹⁶ Prior to that time the limits were 12 services per year plus an additional six services in exceptional circumstances. Patients may also receive up to 10 group therapy sessions in addition to the individual services.

Fees in the *Australian Psychological Society Recommended Fee Schedule* are higher than MBS fees. For example, the current MBS fee paid (Sept. 2012) for item 800010, psychological services lasting 50 or more minutes, is \$122.55.⁹⁷ The recommended fee for a 46-60 minute visit in the APA schedule is \$222, with fees for longer sessions ranging up to \$417 for 91-120 minutes.⁹⁸

The MBS includes fees for medical practitioners who provide services under Better Access, in the form of consultation fees and Referred Patient Assessment and Management Plans. Physicians may also claim focused psychological strategies (MBS fee code 2721, 2725 & 2727), which are defined in that case as 'specific mental health care management strategies, derived from evidence-based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise.' Focused psychological strategies by medical practitioners are subject to the same annual limits as psychological services by clinical psychologists.

Focused Psychological Strategies services are listed in the following box.⁹⁹

Focused Psychological Strategies by Allied Health Providers

- i. Psycho-education (including motivational interviewing)
- ii. Cognitive Behavioural Therapy, including:
 - Behaviour modification
 - Exposure techniques
 - Activity scheduling
 - Cognitive therapy
- iii. Relaxation strategies
 - Progressive muscle relaxation
 - Controlled breathing
- iv. Skills training
 - Problem solving skills and training
 - Anger management
 - Social skills training
 - Communication training
 - Stress management
 - Parent management training
- v. Interpersonal therapy (especially for depression)
- vi. Narrative therapy (for Aboriginal and Torres Strait Islander people)

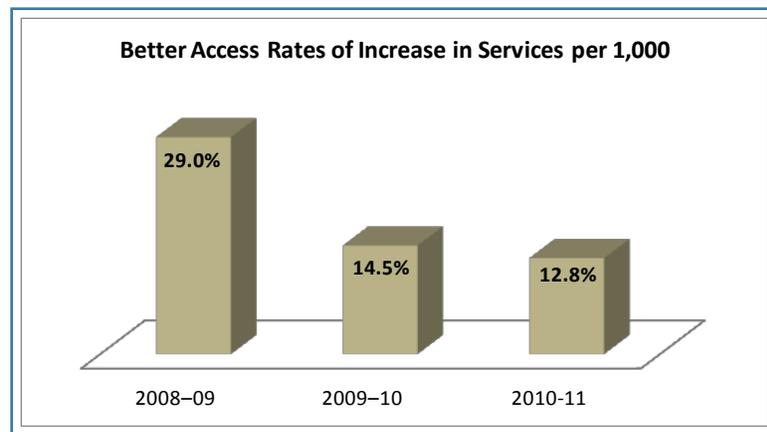
In order to be eligible to provide these services, non-medical providers must be either (i) a psychologist who meets state licensing requirements, (ii) an occupational therapist accredited by Occupational Therapy Australia and having at least two years experience in mental health or (iii) a social worker who is a member of the Australian Association of Social Workers (AASW) and certified by AASW as meeting the standards for mental health. Psychologists who are not registered as clinical psychologists are paid a lower fee for focused strategies services than clinical psychologists who provide psychological therapy. For example, the fee for focused strategies services lasting 50 minutes or more is \$83.25 (as noted above, the fee for a clinical psychology service 50+ minutes is \$112.55). Fees for occupational therapists and social workers providing a service lasting 50+ minutes are each \$73.40.

Better Access to Mental Health Care Utilization

The following figure summarizes the number of Better Access services per 1,000 population reimbursed by the MBS from 2006-07 to 2010-2011. The Better Access plan was introduced in November, 2006; the Australian fiscal year runs from July to June and data for 2006-2007 do not include a full 12 months experience.

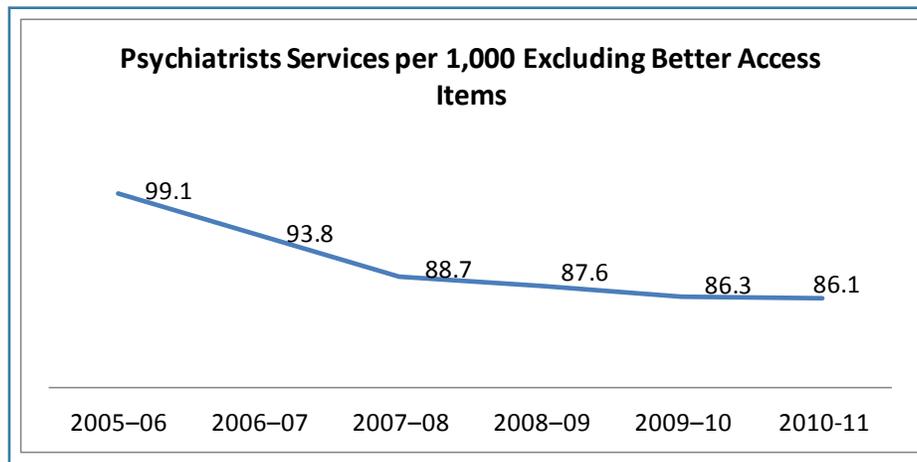
Psychologists provide the majority of services under the plan. Psychological therapy by clinical psychologists accounted for 37.6% of services by psychologists in 2010-11. Focused psychological therapy accounted for 61.9%, with approximately 0.5% comprising other services (e.g. treatment of persons with developmental disabilities and enhanced primary health care). General practitioners provide the second highest level of services, consisting mainly of mental health treatment plans. GPs also provide focused psychological therapy services and family group therapy (these two services together account for approximately 3% of GP Better Access services).

In total, Better Access services increased from approximately 155 per 1,000 in 2007-08 to 259 per 1,000 in 2010-11. Rates of increase were highest in the second full year of the plan and leveled off somewhat during the last two years, although they remained over 12% per year, as demonstrated in the following figure.



Source: Australian Institute of Health and Welfare

Psychiatrists' services shown as measures of services per 1,000 consist of consultations under the *Better Access* plan. Psychiatrist services for other forms of treatment have decreased since 2005-06, as demonstrated in the following figure. It is not clear if the introduction of the *Better Access* plan led to a reduction in psychiatrist services for other treatment, but the size of the reductions in 2006-07 and 2007-08 raise this possibility.



Source: Australian Institute of Health and Welfare

Patients Treated

The number of patients, who received psychologists' services insured by Better Access, and services per patient, are shown in the following table. The category, other psychology, consists mainly of focused psychological services as noted above. Some patients received more than one type of service and for that reason the individual categories do not add to the total. Patients received an average of 5.2 services per year. The stability of services per patient from 2009-10 to 2010-11 indicates that the increases in services per 1,000 population resulted from more people accessing services.

Better Access Patients 2009-10 and 2010-11

Type of Service	Number of Patients		Services per Patient	
	2009-10	2010-11	2009-10	2010-11
Clinical Psychology	210,027	245,197	5.2	5.2
Other Psychology	389,774	433,607	4.8	4.9
Total - Psychologists	576,583	652,626	5.2	5.2

Source: Australian Institute of Health and Welfare

During the first three full years of the plan, a total of 2,016,495 Individuals received Better Access services from psychologists, physicians and allied health providers.¹⁰⁰

Expenditure

The following table summarizes Australian Medicare expenditure from 2005-06 to 2009-10 on mental health related services. As noted above, data for 2006-07 do not include a full 12 months experience. Expenditure data for 2010-11 have not been released at this time (October, 2012).

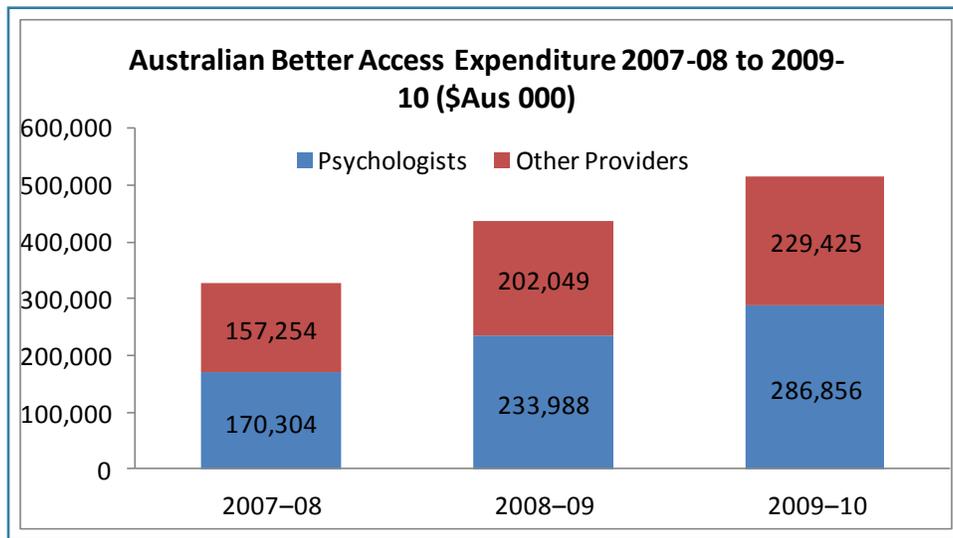
The final two rows in the table show total and per capita expenditure on new items introduced as part of the Better Access plan. General practice data includes miscellaneous psychiatric services in 2005-2006. It has been estimated that approximately 6.1% of total GP Medicare expenditure prior to Better Access was for mental health services that were replaced by the Better Access plan.¹⁰¹

Australian Government Medicare Expenditure on Mental Health Related Services

	2005-06	2006-07	2007-08	2008-09	2009-10
	Amount Paid (\$000)				
Psychiatrist Better Access Consultations		9,199	17,144	19,010	20,435
Other psychiatry	220,579	221,556	223,081	230,109	238,558
Sub-Total Psychiatry	220,579	230,755	240,225	249,119	258,993
GP Services	6,294	68,756	133,449	172,184	194,105
Clinical Psychology		20,974	73,621	105,341	130,003
Other Psychology	2,263	33,423	96,683	128,647	156,854
Sub-Total Psychology	2,263	54,398	170,304	233,988	286,856
Allied Health Providers	134	1,453	6,662	10,856	14,885
Total	229,271	355,362	550,639	666,146	754,839
Expenditure for Better Access Services		133,806	327,558	436,038	516,281
Expenditure per Capita		6.41	15.42	20.15	23.31

Source: Adapted from *Mental Health Services in Australia, 2009-2010*; Table 14.12

Psychologists accounted for more than half of the total expenditure for Better Access Items, demonstrated in the following figure. Rates of increase in expenditure for psychologists' services exceeded rates of increase for other providers (68.4% for psychologists and 45.9% for other providers, respectively, over the three year period).



As noted above, Australians have the option of claiming reimbursement for Better Access services from private insurance when they have it, although they cannot use private insurance to supplement Medicare reimbursement. Estimates of private insurance expenditure were not available. WHO estimates that the sources of total Australian health expenditure in 2010-11 were: government at approximately 70%, out-of-pocket expenditure at 17.5% and other sources, including private insurance, at 12.5%.¹⁰² None of the documents reviewed mentioned private insurance as a significant funding source for Better Access services and, given universal public insurance for these services, it seems reasonable to conclude that additional expenditure from this source would have a minor effect, if any, on expenditure per capita.¹⁰³

Better Access Plan Changes 2011

In its 2011-12 budget, the Australian government announced a change in the number of services available to patients under the Better Access plan, which would limit the number of services per year to 10 instead of 12 and drop the option of six additional services for those with exceptional needs. These changes were effective November 2011. This policy change was met with strong criticism. The Australian Psychological Society carried out an analysis that indicated 13% of Better Access patients, or 87,000 per year, qualified for more than 10 services under the previous limits and that 84% of these persons had moderate to severe conditions. The APA maintained that most of these persons would not be able to access other government funded care.¹⁰⁴

In February 2012, the six additional services for persons with exceptional needs were reinstated for the remainder of 2012.¹⁰⁵ The government budget for 2012 announced \$21 million in funding for the Better Access plan to fund the additional visits between March 1 and December 31, 2012. In explaining the policy, the Budget Papers referred to this period as transitional and noted:

*The transitional period will provide sufficient time for new mental health services announced as part of the Government's National Mental Health Reform package to build capacity and effectively respond to people with more complex needs.*¹⁰⁶

Full details of the 2012 budget amount for Better Access were not found during this literature review. Commentators have indicated, however, that there were no net budget increases for the plan and that the new mental health services referred to in the announcement have not been defined (comments by S. Rosenberg and P. McGorry of the University of Sydney, Sept, 2012)¹⁰⁷

Evaluation of the Better Access Plan

In order to evaluate the success of the Better Access Plan, a framework for evaluation was developed at the inception of the program in 2006. The key objectives of the evaluation were to determine the degree of success of the program in improving access to mental health care and outcomes for patients; and in providing more effective and efficient care by mental health professionals through inter-disciplinary collaboration. Evaluation efforts were ongoing throughout the first four years of the plan and involved many stakeholders and consumers. An evaluation report was prepared jointly by the University of Melbourne and the University of Queensland and published in 2011.¹⁰⁸ Conclusions from the report are summarized in the following box.

Findings from an Evaluation of the Better Access Program 2006 - 2010

Access to mental health care for people with common mental disorders was improved.

Rates of utilization of mental health services increased for all sectors of society, including relatively disadvantaged socio-economic groups.

Significant numbers of people who did not previously receive mental health care received services under the plan.

Consumers have positive attitudes about the *Better Access* delivery model. They have positive outcomes as measured by a number of standardized psychological outcomes.

Preliminary analysis of outcome and cost data for consumers seen by psychologists through *Better Access* suggests that the initiative is providing good value for money (comparative data were not available for other providers).

Achievements of the plan were realized without adverse effects on other components of mental health services.

The plan may have had a positive effect on collaboration among mental health professionals.

Source: Better Access Evaluation Report Key Findings

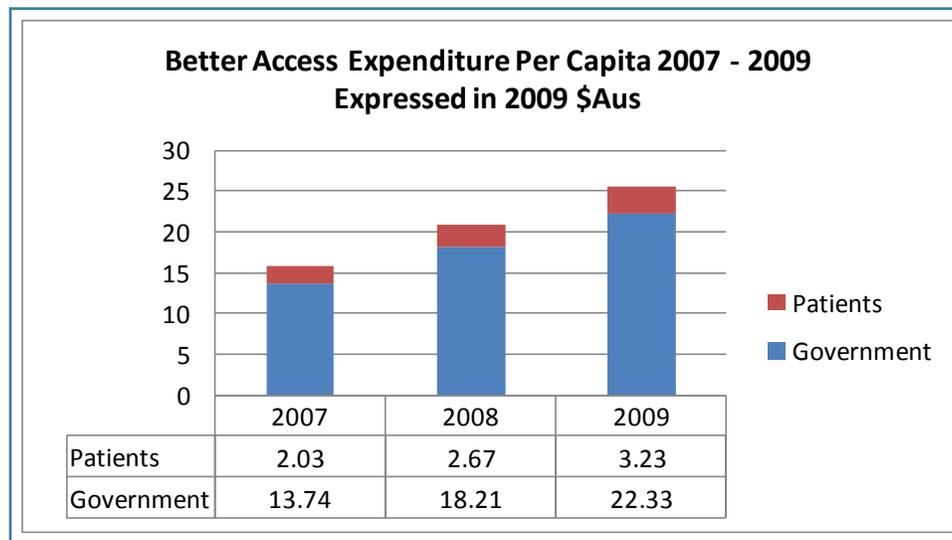
The plan has incorporated multi-disciplinary workshops to encourage collaboration and networking between GPs, psychologists and allied health care professionals. The evaluation report found that over 12,000 persons had attended these workshops and that there had been a positive effect on multi-disciplinary networking, although these arrangements were in their early stages at the time of the study. Interviews with individual practitioners found that mutual appreciation of the roles of the different professions had increased. There were some concerns among GPs that they were not receiving sufficient feedback about the progress of referred patients as well as concerns from the other professions that sometimes they did not receive adequate referral information from GPs.

Other evaluations of the Better Access plan have also been positive. For example, the Australian Psychological Society conducted a survey of consumers who received psychological care under the plan and found that 90% felt that the treatment they received had led to significant or very significant improvement.¹⁰⁹ A 2011 paper in the Australian and New Zealand Journal of Psychiatry reported that the program had become very popular with the public and its costs were 2.5 times the initial projections. The author concluded that the program had achieved its main objective of improving access although some discrepancies in access remained.¹¹⁰

Data analysis for the 2011 evaluation report showed that approximately 3.4% of the population received services in 2007, increasing to 5.3% in 2009. The share of persons treated under the plan who were treated by clinical psychologists increased by 2.9 percentage points, from 13.9% in 2007 to 16.8% in 2009, while the share of persons seen by consultant psychiatrists decreased by 3.5 percentage points, from 12.4% to 8.9%.

The report concluded that, *the high level of uptake should be viewed positively rather than negatively, because it indicates that substantial numbers of consumers with previously unmet need for mental health care are now receiving it* (p. 45).

The evaluation analysis provides summary utilization statistics by year for calendar years 2007 to 2009, including the amount charged, the amount bulk billed to MBS and the amount of patient co-payments. The total charged for services under the plan increased from \$331.6 million in 2007 to \$547.2 in 2009, an increase of approximately 18.2% per year. Expenditure per capita, including co-pays, increased from \$15.77 to \$25.56, demonstrated in the following figure.



Discussion of the Better Access Plan

The *Better Access* plan is a privately delivered, publicly funded model. The payment mode is fee-for-service. As a result, the plan is open-ended with regard to expenditure, although nominal budget amounts are assigned each year. The following considerations are relevant when considering the appropriateness of this model to the Canadian health care system.

- i. The rapid uptake of the plan by the Australian population and health care providers has resulted in utilization and expenditure increases that were not anticipated by government. Data shown above reveal increases of over 12% per year in both services per capita and expenditure per capita in the most recent year for which data were available. Increases were higher in earlier years. Increases appear to have resulted mainly from an increased number of persons accessing services and data from the last two years suggest that services per patient have stabilized.
- ii. Increases in expenditure appear to have been at least partially responsible for a decision in 2011 to limit services per patient from a maximum of 18 per year to 10 per year. Although the provision for six additional services above the 10 service limit was reinstated for a transitional period ending in December, 2012, there is no provision for services above the limit for those with exceptional needs beyond that time. The 10 service limitation has resulted in acrimony between the government and APA, which estimates that 87,000 people will be adversely affected. The APA and government also disagree about the degree of severity for patients targeted by the plan, with APA maintaining that the affected persons have significant degrees of acuity and that alternatives to extended treatment under Better Access are not presently available in the public system. The 2011 evaluation report also concluded that most persons who used the service had significant levels of distress.
- iii. The *Better Access* plan allows billing above government rates if providers choose to bill patients directly. In 2009, only 35% of clinical psychiatry items were bulk billed (where billing above government rates is not permitted). The rate of bulk billing increased to that level from 27% in 2007. Patient co-pays for clinical psychotherapy services that were not bulk billed averaged \$32.15 per service in 2009.
- iv. The *Better Access* system is meant to encourage collaboration among professionals. It retains the gatekeeper role for general practitioners, however, who must generate a referral to psychologists and other providers, develop a treatment plan and review progress after the first six sessions by a psychologist or allied health provider.

VIII.3 Success Factors in the United Kingdom and Australian Models

The characteristics of the UK and Australian programs to provide better access to psychological therapy services are very different in terms of how care is funded and delivered. But they also share common characteristics, which can be seen as factors contributing to the success of such programs, and which can be incorporated in efforts to expand access to psychological therapies in countries with different cultures and systems of health care organization.

- i. The two programs have clear goals for treatment and outcomes.
- ii. Both programs have detailed reporting mechanisms – through the MBS administrative system in Australia and the mental health reporting system in the UK.

- iii. Both programs focus on specific conditions, which consist of mild or intermediate cases of anxiety and depression. The Australia program is also treating a significant number of persons with more severe conditions and government has committed to developing other resources for these clients in future. Programs to deal with severe and long lasting conditions are being developed as part of the expansion of IAPT in the UK.
- iv. Clients of the service are recognized as important in decisions about therapy. The UK mental health programs profess to be guided by the slogan, 'No decisions about me, without me.'
- v. Community groups and stakeholder organizations are recognized in both countries as having key roles in the larger mental health environment. Support mechanisms within families, communities and workplaces are also seen as key to successful mental health programs.
- vi. Both programs have a clear articulation of the roles of psychological therapy providers. Both have structured levels of service that include highly trained clinical psychologists and allied health providers.
- vii. Both programs incorporate provider training programs, although the UK IAPT program is much more highly structured in this regard and has incorporated a planned expansion of services with provision for training a substantially increased workforce, expanding delivery sites and, in future, incorporating incentives for quality in payments to provider groups.
- viii. Both programs include evaluation criteria. The Australian program established an evaluation framework when it was established, with ongoing evaluation. The UK system has a series of indicators that allow measurement of success in reaching targets. Both programs are included in an annual mental health reporting process.

VIII.4 United States

Psychology is well established in the U.S., with the American Psychological Association reporting approximately 137,000 members and 93,000 practicing psychologists¹¹¹. There is no uniform payment model; however, with private practice psychologists funded by a mixture of out-of-pocket payments, private health insurance and Medicaid coverage for those who qualify due to low income.

According to the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ), annual treatment costs for mental disorders among the non-institutionalized civilian population¹¹² rose from \$35 billion in 1996 (in 2006 dollars) to nearly \$58 billion in 2006; the number of patients treated for these disorders increased during the same period from 19 million to 36 million. Mental health was the most expensive medical condition, followed by heart disease, cancer, trauma-related disorders, and asthma. Interestingly, the cost per patient for mental health treatment was lower than any of the other top five diseases and decreased during the ten year period from \$1,825 to \$1,591.¹¹³ (The cost per patient of treating cancer, the most expensive condition, increased from \$5,067 to \$5,178 during the same period.) Another AHRQ study, which focused on non-institutionalized adults age 18 – 64, found that 23.9 million persons in that age group received mental health services in 2007, with expenditures of \$36.5 billion¹¹⁴.

There is a growing interest in integrating psychology and other mental health providers into primary care practices. A 2012 AHRQ research article reported the results of a Mental Health Forum and Town Hall at its annual meeting that discussed the challenges of dealing with mental health in primary care.¹¹⁵ Key issues include the lack of training among GPs in mental health treatments and the difficulty they encounter in referring patients to mental health professionals in the community. The participants agreed that GPs and mental health providers should be integrated in primary care practices, although there are challenges to both groups of professionals in adapting to such models. Challenges include training, treatment styles (e.g. short visits by GPs and a tradition of 50 minute sessions by psychologists), communication between professionals and payment mechanisms in which mental health providers and family physicians are not funded by the same payment agency. In models where these problems have been overcome, large payoffs have been realized. A notable example was a large health plan in which medical and behavioral providers and health coaches provided advice by telephone to an insured population of about 15,000 Medicare patients. This integration initiative was reported to have cost \$16 million and, within one year, saved \$40 million on avoided health costs.

Psychology is insured by private insurers but recent trends indicate that there has been a shift from psychological interventions to pharmaceuticals. According to a 2010 article in the APA Monitor on Psychology, quoting a federal Medical Expenditure Panel Survey (MEPS), between 1997 and 2008, ... *30 % fewer patients received psychological interventions. This trend was noted particularly among those with anxiety, depression and childhood-onset disorders.*¹¹⁶ The article attributes this trend to the influence of managed care policies in the U.S. private health insurance industry which, ... *has resulted in controlling provider fees, strict limitations on episodes of inpatient care and reduction in the average number of outpatient visits per patient treated.* Similar restrictions were not placed on drug therapy, leading to a substitution of drug therapy for cognitive therapy. The effects of managed care on treatment choices were compounded by aggressive marketing by pharmaceutical companies.

Another AHRQ study, which focused on treatment for depression in Medicare patients, found that over a ten year period ending in 2005, diagnosed rates of depression in the elderly increased from 3.2% to 6.3%. Anti-depression medication use increased during this period while rates of psychotherapy decreased. By 2005, less than half of patients with major depressive disorder received psychotherapy.^{117, 118}

Discussion of the American Approach

The US and Canadian health care systems have many similarities in terms of provider roles and modes of practice. Major differences exist in funding, however, with a mainly private sector funding system in the US and comprehensive insurance in Canada for medically necessary physicians and hospital services. Clearly, the type of funding and rules imposed by, or negotiated with, funding agencies have the potential to influence modes of practice.

Psychology is funded primarily by the private sector in both Canada and the US. Health insurers and employers who make insurance purchases on behalf of their employees may under value psychology as a component of insurance plans. Differential terms for funding physicians, prescription drugs and mental health services, including psychology and psychotherapy, have led to a decrease in

psychology services in the US and an increase in pharmaceutical treatment. It is not known if a similar trend exists in Canada, but it is a concern that should be addressed by both psychology and the medical profession, in the interests of appropriate treatment for patients.

The integration of primary care physician practice and psychology has sparked considerable interest in both the US and Canada. There is an opportunity to pool experience and, where possible, join forces to promote the adoption of evidence-based best practices in integrated primary care.

VIII.5 Netherlands

Netherlands has an innovative model of publicly insured psychologists services known as the primary care psychologist (PCP). The description in this section is drawn from J Dirksen¹⁹, a professor of clinical psychology at the Radboud University of Nijmegen, who also has been a practising PCP for 30 years. The PCP concept was started in 1978 by a group of innovative psychologists and has since grown to become an essential part of the Dutch primary care health system. PCP services are publicly insured for the entire population up to eight visits per year. Many people have supplementary insurance that provides coverage up to 12 visits per year. PCP certification requires a four year Masters of Psychology degree followed by two years of additional training in which the PCP candidate works four days per week under supervision and attends college for one day per week.

The PCP works in close contact with general practitioners and generally limits his or her practice to the same geographic area as GPs in the community. This is considered to be an advantage as it provides familiarity and insight into local culture and community concerns. Approximately 60% of PCP patients are referred by GPs and 40% are self referred. PCPs have solo practices or work in health centres with other PCPs or a mixture of PCPs and physicians. There is close contact between PCPs and GPs in the form of information sharing and consultation about the patient's condition. Dirksen reports that GPs often ask patients how things are going with their psychologist visits, a strategy which tends to bring patients into a collaborative relationship with the health professionals.

PCPs usually limit their practices to primary care and refer more complex cases to secondary or tertiary care psychologists. Nonetheless, they are able to diagnose and treat the full range of psychological problems. Dirksen reports that approximately 14% of patients seen by PCPs are referred to higher levels of care. Psychologists and psychiatrists working in secondary and tertiary care are normally employed in addiction centres or mental hospitals. In many cases, clients who have been referred by PCPs return to the PCP for follow-up care after their course of treatment.

The limits on insured care do not appear to be a major concern, with 75% of clients completing their course of therapy with the PCP within eight visits and 90% completing therapy within twelve visits. The average course of therapy lasts 21 months. Of clients who visit PCPs, 80% are diagnosed and treated and, of those, 60% are considered to have improvement or strong improvement, as measured by psychological testing instruments.

As of 2008, the Netherlands had a population of 16 million. There were 1,150 PCPs and 84,000 persons who received treatment by PCPs in 2007. Financial information on the cost of PCP services and other mental health services was not available.

VIII.6 Finland

The health care system in Finland is decentralized and municipalities have responsibility for the delivery of health care services. The health centre is the focal point for the delivery of primary care. Health centres deliver the following services:

- Monitoring and policy planning based on health information on the catchment population;
- Diagnosis and treatment of diseases (general practitioner level, includes also services of GP run local hospital services);
- Home nursing;
- Dental/oral care;
- Rehabilitation and service of assistive technology;
- Emergency care (ambulance service and action at sites of catastrophic events);
- Occupational health care;

Many health centres also deliver outpatient mental health services (instead of being placed at the level of specialty care) and substance abuse services.

Finland puts a lot of emphasis on occupational health. They use psychologists to assist in improving work and well-being in the workplace. Occupational health psychology is grounded in Finnish legislation¹²⁰. A masters' degree in psychology is required to be licensed as a psychologist in Finland. In the workplace psychologists are focused in two areas:

- i. Vocational guidance and personnel assessment - Employment and Economic Development Offices offer vocational guidance and career planning in Finland. The service is free of charge to Finnish citizens.
- ii. Occupational counseling is targeted especially to young people making vocational choices and to vulnerable groups.

Approximately 40 per cent of occupational health clinics have occupational health psychologists' services available and 90% of workplaces have access to occupational psychology services. Prevention of work stress, promotion of work engagement, and mental health are the goals of occupational health psychologists¹²¹.

Health services and mental health services in particular are going through changes in Finland as municipalities, with greater decentralization, are setting their own priorities for community based and primary care services. Some commentators believe that mental health is losing out and not all municipalities are in tune with national guidance.

IX Models for Enhanced Access to Psychological Services

As noted in the *Environmental Scan*, the MHCC recommended that 2% of present health expenditure in Canada be reallocated to mental health. We estimate that a 2% reallocation to mental health would be valued at \$4 billion in 2011. It has been estimated, as well, that the current cost of mental illness and addiction, based on 2003 studies undertaken for the commission, would be in the area of \$60 billion. The MHCC report also recommended a reallocation of spending within the mental health envelope with a view to achieving greater effectiveness and efficiency. It is difficult to estimate the economic payoff from these reallocations but it is clear that very large gains could potentially be realized. For example, if these reallocations could reduce the burden of untreated or under-treated mental illness by even one-third, the payoff arguably could be as high as \$20 billion (1/3 of \$60B), in which case there would be an economic benefit cost ratio of 5:1.

IX.1 Economic Considerations for a Business Case

The essential elements of a business case are the prospect of a positive return on investment (ROI), in the form of revenue or benefits, that exceeds the amount invested and a demonstration that the activities proposed are an appropriate way to achieve the objectives that are being pursued. In the case of improved mental health, there are many activities that have the potential to provide positive benefits. There are also many actors who stand to benefit, most notably the individuals whose mental health can be improved, their communities, employers, government and society at large.

Return on investment in mental health is difficult to measure for a number of reasons, including the facts that (1) benefits often accrue over a longer time span and are harder to quantify than costs, (2) indirect benefits are hard to measure, especially when they occur in different economic sectors (e.g. reductions in costs that occur in the justice system) and (3) factors such as socio-economic conditions and chronic disease can impact the effectiveness of mental health interventions.¹²²

The Canadian Institute for Health Information (CIHI) published a review of return on investment in mental health promotion and prevention in 2011, which was carried out by researchers at the Canadian Policy Network.¹²³ The report found a lack of substantial evidence for ROI in most mental health promotion and prevention initiatives, which may be a result of the evidence base, since there are few randomized controlled trials (RCT) or other convincing studies to measure positive effects. The authors explained this circumstance in terms of the focus for most technical studies to date:

There appears to be greater emphasis in the literature on effectiveness interventions than on economic evaluations. This may be because of the difficulties related to economic analysis, including a lack of standard definitions, time lags from inputs to outcomes, accruals typically needed for cross-sector analysis and the many confounding factors and variables to consider (pg. 24).

A significant amount of work is emerging on the effectiveness of mental health promotion and illness prevention interventions, especially in the area of improving the quality of life. Unfortunately, less is known about the economic returns on these investments (pg. 26).

An important study to calculate the costs and benefits from early intervention in mental disorders was carried out recently by researchers in the UK, commissioned by the Department of Health (Knapp et al.)¹²⁴. The study used systematic reviews of existing research together with econometric techniques to estimate costs and benefits across public and private sectors of the economy. Benefits were calculated for the NHS, other public sectors (social services, prisons) and non-public sectors (notably reductions in productivity losses and crime). Benefits to patients in terms of improved wellbeing are not included in the calculations, resulting in ROI data that reflects real, quantifiable savings to society. Selected examples are shown in the table below. Economic pay-offs were expressed as total £ saved for every £1 of expenditure. Although the study data were calculated in UK£, normalization of the results to a base of £1 allows the data to be used as ratios, which can be translated to other currencies.

The disaggregation of ROI by sector illustrates that benefits of improved mental health are often diffused. In the excerpts shown here, most or all the costs of the intervention would occur in the health sector. ROI greater than 1 in that sector indicate that the costs of early intervention are less than the costs of other treatment that would be required in the absence of early intervention. Diagnosis and treatment of depression at work is an example of a condition where early intervention provides a modest payoff in the health sector but larger payoffs in other sectors. Early intervention in psychosis provides a ROI of 10:1, with half of these payoffs occurring in the health sector. Prevention of conduct disorder is an example of extraordinary large payoffs in all sectors.

Economic Payoffs from Early Intervention (Ratio of Benefits to Costs) by Sector in the UK

Early Intervention for:	Health Sector (NHS)	Other Public Sector	Other Sectors	Total
Conduct disorder	1.08	1.78	5.03	7.89
Medically unexplained symptoms	1.01	0	0.74	1.75
Diagnosis and treatment of depression at work	0.51	0	4.52	5.03
Psychosis	9.86	0.27	8.02	17.97
Prevention of conduct disorder through social and emotional learning programs	9.42	17.02	57.29	83.73

Source: Knapp et al. Table 13, p. 39

Cost effectiveness is closely related to return on investment but the two concepts differ in important ways. Cost effectiveness in health care means that an activity is effective in bringing about desired outcomes and that it is the most efficient way to do so in terms of resources used. In cost effectiveness studies, it is not necessary to estimate the dollar value of benefits. Instead, benefits may be calculated in terms of the value, or utility, perceived from the standpoint of those who receive treatment. An example is the use of quality adjusted life years (QALY) to measure benefits and cost per QALY to measure benefits relative to costs.

There is a significant literature that demonstrates the cost effectiveness of psychological services. A comprehensive literature review in 2002¹²⁵ found that:

Psychological interventions can effectively treat a wide range of child and adult health problems, including depression, generalized anxiety disorder, panic disorder, post-traumatic stress disorder, eating disorders, substance abuse, and chronic pain.

There is mounting evidence that there are also effective psychological treatments for diseases and disorders that are routinely seen in primary care medical practices but that are typically difficult to medically manage.

Psychological therapy has been shown to be less expensive than, and at least as effective as, pharmaceutical therapy for a number of common conditions.

Psychological interventions also have the potential to reduce health care costs, as successfully treated patients typically reduce their utilization of other health care services. In some instances, the reduced cost to the health care system may actually be greater than the cost of the psychological service, thus resulting in a total cost offset to the system (pg. 1, 2).

An extensive review conducted for the European Pact for Mental Health and Wellbeing in 2011 (McDaid et al.) built on the Knapp et al. study by supplementing the evidence of ROI with evidence on cost effectiveness measured through cost per QALY for intervention in specific mental health conditions¹²⁶. The authors cite a cost threshold of less than £30,000 per QALY gained as the generally accepted criteria to define cost effectiveness in developed countries. Research evidence for selected conditions reviewed in their studies is summarized in the following table.

Cost per QALY Gained in EU Countries for Mental Health Interventions

Treatment or Condition	Cost per QALY Gained
Cognitive therapy for postpartum depression (UK)	£4,900
Stepped care for depression (Netherlands)	£4,367
Collaborative care to manage/prevent depression in people with chronic physical health problems (UK)	£4,043
Collaborative care for early treatment of Type II diabetes	£3,614

Summarized from McDaid et al.

Economic considerations are important in designing programs to alleviate health problems and are complementary to the goals of improved health and functioning. As expressed in a NHS guide for investing in improved mental health for persons with long term medical conditions, objectives for the health care system should be “to improve quality of life and quality of care, and to generate service efficiencies and cost savings.”¹²⁷

This section discusses models of psychological care that have the potential to provide enhanced access to professional care for Canadians who need assistance in dealing with mental health and addiction problems. The focus is to describe models that have the prospect of being both clinically effective and economically efficient, and which are consistent with the Canadian culture and health system. The issue with which we are concerned is access to psychologists services and therefore discussions are limited to the venues within which psychologists services are delivered. While recognizing that psychological services are provided within the educational sector, the military, corrections services and other sectors of the economy, the models we discuss are meant to be models for the public and privately funded health sector (although they will obviously have relevance for services delivered in the military and other settings where organized health care is provided).

Provincial governments have accepted the idea that there are shortages of physicians in Canada, and have endorsed policies for increased supply that has led to a 67% increase in Canadian medical school graduating class size between 2001 and 2011.^{125,126} Assuming this to be evidence of governments' determination to provide adequate levels of appropriate care, it is a logical next step to engage more members of other professions to provide care where they are uniquely capable of doing so. This is the case with mental health; psychologists are specifically trained to diagnose and treat the full range of mental disorders. Engaging psychologists to treat or direct treatment of mental disorders provides a better option to patients than treatment of symptoms. Using psychologists to treat mental conditions also frees up family physicians to concentrate on the diagnosis and treatment of medical conditions.

As pointed out Section V, the MHCC finding that 20% of Canadians have mental health problems and that only one-third received care leads to the conclusion that 14% of Canadians require care and are not receiving it. It is necessary to rationalize as well as to increase supply to meet these needs, and the MHCC recommendation for reallocating expenditure recognizes this fact. Effective mental health care is bound to be more cost effective than treatments of symptoms that do not alleviate the underlying mental health condition.

IX.2 Models for Canada

There are two key considerations in proposing models for new health care services: (1) how are they to be delivered; and, (2) who pays? The answers to these questions will vary according to the recommended delivery models. It is also important to recognize the structure of the present health system with a view to integrating new care models with existing ones in order to enhance patient centred care, and to minimize the necessity of new administrative structures in public systems. In the sections below we discuss three general models: enhanced collaborative care, fee-for-service and an adaption of the model used in the UK IAPT program.

IX.3 Collaborative Care Models

In 2004, provinces committed to providing access to multidisciplinary primary care teams by 2011. While progress toward this goal has been uneven, multidisciplinary teams are prevalent in Ontario, in the Family Health Team (FHT) models; Quebec, in Local Community Service Centres (CLSCs) and

Family Medicine Groups; and Alberta, where approximately three-quarters of the population are served by 39 Primary Health Networks (PHN)¹²⁸. These practices have received financial incentives in provincial funding to provide multidisciplinary care and extended hours of availability.

In Quebec, 682 psychologists practice in CLSCs. The OPA reports that FHTs in Ontario have 21 psychologist FTEs. Alberta reports 34 psychologists in collaborative care with this number increasing, albeit slowly. As noted in Section VI on Canadian models, a study of collaboration between family physicians in Ontario found that “75 per cent of the family physicians surveyed believed that integrating psychologists into primary care would improve the quality of services provided.” In Alberta, success has been reported with the Shared Health Care and Behavioural Health Consultant services, which provide support by mental health practitioners in group practices. Models of collaboration in Winnipeg were also discussed.

The models reviewed, along with the international literature review and models documented by CPA in its presentations to the Premiers Council, make it clear that collaboration with psychologists offers considerable advantage for patients and physicians. It is also clear that there is no single model that stands out as an exemplar. Rather, there are a variety of models based on local circumstances and the preferences of both physicians and psychologists. Accordingly, we have chosen to outline the key factors that will support models of collaborative care, which can act as a guide for developing new models. These factors are outlined below.

Collaborative Primary Care

- i. Collaborative care models should be managed by group practices (e.g. FHTs, CLSCs, PHNs) and group practices should adopt administrative structures that support collaborative management and shared professional services. Participation in ownership by professionals in the practice, joint decision-making and professional management where the size of practices permits are examples.
- ii. Designated funding should be provided by provincial RHA or MOH. This funding should be in the form of capitation or global budgets based on patients served, number of professional FTEs and the range of services provided. The inclusion of psychologists services in the funding envelope should be seen as a logical progression of the overall transition to more effective and efficient primary care in Canada.
- iii. Budgets should be managed by the practices, which would have discretion to determine the appropriate ratio of physicians, psychologists and other health professionals to provide optimal care. Staffing guidelines for the mix of professionals should be developed by professional associations (e.g., CPA, College of Family Physicians).
- iv. The roles of psychologists should include the following activities:
 - Assessment and diagnosis
 - Consultation and education with team members

- Program and service development and evaluation
- Treatment of complex, chronic, co-morbid conditions involving mental and behavioural health and addictions
- Supervision of psychologically related services by other providers, as appropriate

The actual mix of these activities will depend on circumstances and requirements within the collaborative practices. Education and consultation should be a prominent feature of all models to ensure that mental health needs of patients are identified and dealt with as part of the case management process. Where services such as psychotherapy or CBT are required, psychologists will normally be the most qualified team member to either provide or manage care. Decisions on these issues are best made between members of the care team.

- v. Stepped care programs to care for patients with mental health issues should be incorporated in treatment plans. In stepped care, the intensity of psychological interventions typically begins at a low level and progresses to more intensive levels when required. This approach allows many patients to be treated by nurses, social workers or others with appropriate training, under the guidance of a psychologist.
- vi. Collaborative models should use electronic health records and appropriate information technology to ensure that all test and treatment results can be shared by team members on a 'need to know' basis, in order to share test results, professional insights and to provide the most appropriate care without duplication of effort or unnecessary inconvenience to patients.

Specialist Practice Models

The review of Canadian models found examples of psychologist and physician collaboration across a number of health conditions. These include psychological conditions and disorders but also other kinds of health conditions such as cancer, obesity, diabetes, head injury and dementia, chronic pain and heart disease.

- i. Specialist collaborative models should be managed through Regional Health Authorities or hospitals.
- ii. Dedicated funding should be provided as part of the budget for the specific specialty service, based on number of FTEs at negotiated rates.
- iii. The roles of psychologists should be focused on diagnosis and co-education, especially where there are medically unexplained circumstances or where the conditions treated predispose patients to anxiety or depression.
- iv. Psychologists can carry out most or all of the responsibilities presently assigned to psychiatrists in psychiatric inpatient or outpatient care. Use of psychologists may be especially attractive for hospitals experiencing unsuccessful recruitment of psychiatrists. With appropriate documentation of experience, the psychologist option could be adopted by more

hospitals with a rate of growth that reflects a needs-based model and available supply of professionals.

- v. Collaborative mental health models that include psychiatrists, psychologists, and mental health nurses have the potential to provide cost-effective, stepped services for hospital inpatient and ambulatory care clinics that align with patient needs. Collaborative models should be tested in a number of academic centres, with a view to encouraging the widespread adoption of successful models.

Costs of Collaborative Care Models

The relevant costs of integrating psychologists into primary care and specialist collaborative care models will be the incremental costs associated with employing psychologists and making any other changes necessary to expand the scope of services to provide mental health care according to evidence-based best practice. Psychologists costs could be estimated based on a benchmark remuneration of \$205,000, consisting of salary, benefits and expenses of practice (35%), and institutional overheads (8%). Other costs include allied health providers who can assist in providing mental health care, such as mental health nurses and social workers. The extent to which collaborative practices would wish to expand these services would depend on the size of the practice and the number of persons who require mental health services.

For purposes of costing, it has been assumed that primary care models with ten or more physician FTEs could support one full time psychologist. Higher ratios of psychologists would be required in practices that serve populations with high mental health needs, such as those serving inner-city populations with high incidences of poverty and addiction. As noted in the *Collaborative Primary Care Model*, professional judgment is required to define optimum ratios of professional skills in these models. In the case of specialist care, the size, composition and scope of specialty services providing mental health care will be an administrative and professional decision to be made by hospital administrations and RHAs. Using the ten to one ratio of physicians to psychologists in a primary care practice, and further assuming that a collaborative practice could treat a population of 2,000 persons for each physician FTE, the incremental costs of including psychologists in a collaborative practice would be equal to \$205,000 for a population of 20,000, which would be equivalent to \$10,250 per 1,000 persons covered.

It is important to note that the assumptions in the cost estimates above imply a ratio of one primary care psychologist for every 20,000 persons served by collaborative primary care models. Clearly, psychologists could not assume major responsibilities for treatment in these circumstances but would provide a range of consultation and educational support for physicians and allied health care professionals, who in turn would provide most patient care. Psychologists would likely provide care for patients with the highest level of acuity, assuming other staff could provide care for low to moderate intensity cases. The professional judgments necessary to decide how best to structure the mixture of skills necessary to provide optimum mental health care in a collaborative practice are the domain of psychologists and physicians and will need to be informed by evidence-based best practices.

Consequently, we have included a recommendation to have staffing guidelines determined by professional associations, which have the necessary expertise to determine these matters.

IX.4 Fee-for-Service Models

Estimates in the *Environmental Scan* indicated that fee-for-service or contract payments to private practice psychologists in Canada presently are in the area of \$950 million annually. Most of this expenditure is made by clients, insurance firms, or workers compensation boards. Financing of these existing services is clearly an issue in introducing new models. A universal psychologists insurance plan, along the model of physicians fee-for-service, would transfer most present expenditure to government. Access for groups that cannot afford services at present would have to be purchased at additional costs.

There are compelling arguments for providing more support for the cost of fee-for-service psychology through employer insurance, given that lost productivity resulting from mental illness and addiction is estimated to be approximately \$20 billion annually and that employers would benefit directly from recovering these losses.

An authoritative study in the UK by the National Institute for Health and Clinical Excellence (NICE)¹²⁹ estimated that employer losses from mental health issues in the workplace were equivalent to approximately £1 million per year for every 1,000 employees at 2009 wage levels (approximately \$1.5 million Cdn). These losses occur as the result of time lost, reduced productivity by employees who report for work with diminished capacity and increased staff turnover. The report maintains that one-third of these losses could be recovered with appropriate actions, including prevention, early identification and treatment. Applying the one-third recovery estimate to Canadian data suggests that employers could expect to recover \$6 to \$7 billion annually of the \$20 billion losses cited above.

Insurers also stand to reduce costs of providing disability insurance if employees who need psychological assistance can be treated in a timely manner, preventing time lost for some and reducing the length of disability claims for others. Further, increasing the coverage through removal or amelioration of limitations, offers an opportunity to improve care and decrease costs linked to employee disability. The following measures could be undertaken with a view to increasing insurance coverage for private practice psychology services:

- i. Employers need to be educated in the economic benefits of providing enhanced employee insurance coverage for psychologists services
- ii. Insurers should include psychologists services as a standard benefit in extended health benefit plans, reduce conditions that limit the period of treatment and accept self-referrals for treatment
- iii. Governments should provide incentives for enhanced insurance of mental health care by insisting that firms bidding on substantial government contracts provide employee mental health insurance up to a designated minimum standard

- iv. The federal and provincial governments should show leadership by making modifications to coverage provided under government employee insurance plans to increase coverage and reduce limitations on the amount of benefits per patient
- v. Workers' compensation boards should consider increasing coverage with a view to reducing time lost in disability; this enhancement could be supported by premiums for industries where there is a high risk of short and long-term disability through stress and addiction

Costs of a Fee-for-Service Model

The costs of fee-for-service care by private practice psychologists at present is estimated to be approximately \$950 million. Authoritative estimates quoted in other sections of this report indicate that effective demand (i.e. the desire to purchase and the financial resources to pay the going price) for care provided through private practice is constrained by the cost of accessing services and the inadequacy of coverage through public channels and private insurance.

In order to estimate the costs of a fee-for-service program with full funding by either public or private sources, and free of constraints on the number of services funded, it is assumed that an insured population would use approximately 5.5 services per person treated. This estimate is in line with actual experience in the UK IAPT program and the Australian Better Access program. The prevalence rate for treatable mental health problems is assumed to be 20% (as estimated by the MHCC and other authoritative sources). A further assumption is that 50% of those who require care would obtain it – an estimate used in the UK program targets. An average fee of \$150 for a one hour service (or 50 minutes of patient contact plus documentation) was used to estimate cost per service. Using these assumptions, the cost per 1,000 insured persons would be \$82,500. If the entire Canadian population were covered by a fee-for-service program, the potential annual cost would be \$2.888 billion.

IX.5 Models Based on the IAPT Experience

The IAPT model was described in *International Models and Access to Psychological Services*. It offers advantages where there is a desire to provide a comprehensive approach and to incorporate training and rationalization of roles in the program. It is considered to be especially effective for the treatment of anxiety and depression. The program was not meant to substitute for existing services, but to provide access to the most appropriate levels of care for persons who are not receiving treatment or assistance at present. Although the UK IAPT model is national in scope, in Canada, provinces could choose to adopt the model and to roll it out incrementally, as was done in the UK. The existence of training programs in the UK and a considerable body of evidence about the most effective means to deliver IAPT will be an advantage when planning implementation. Characteristics that would facilitate adoption of the program to the Canadian context are:

- i. Programs would be managed by RHAs with designated funding from provincial MOH. Training programs would be delivered by universities or community colleges, depending on the intensity of therapy to be provided by students (high intensity or counseling and assistance). On-site training would be an important part of the training programs, allowing for the provision of care on a residential model, while professionals are being trained.

- ii. Delivery sites would be concentrated in existing practice environments, allowing efficiencies in administration, professional collaboration and economies of scale in providing treatment. The following sites could host IAPT programs:
 - Hospital ambulatory care clinics
 - Community mental health centres
 - Large primary care group practices
- iii. Roles of psychologists would include:
 - Team leaders
 - Supervisors
 - Educators
 - High intensity care, primarily in the form of cognitive behavioural therapy.
- iv. Roles of other health care providers would include:
 - Social workers and others who complete designated courses – psychological well being counseling

Psychological wellbeing professionals (PWP) provide services, described as *high volume, low intensity care*, specifically, counselors undertake patient-centred interviews, identifying areas where the person wishes to see change, make an assessment of risk to self and others, provide assisted self-help, liaise with other agencies and provide information about services. This work may be face to face, telephone or via other media. PWPs work under supervision and refer on those people, who require it, for high intensity therapy.¹³⁰

Costs of an IAPT Program

UK initial supply projections estimated a requirement for 40 IAPT teams per 250,000 population. Team sizes vary and a detailed review of the data suggest that at maturity there will be one therapist for every 5,572 persons of working age¹³¹. Projections used as guidelines in the program call for approximately 900,000 persons treated by 6,000 therapists annually when the program is mature – an average of 150 patients seen by each therapist, with 50% of those treated moving to a cure. The composition of teams between high intensity therapists and psychological well being counselors is projected to be 60% and 40% respectively. These supply targets will vary with local circumstances and teams will have different ratios depending on these circumstances and the types of service that are offered.¹³²

Salaries presently paid by NHS vary by type of therapist and level of responsibilities. Salaries for high intensity therapists range from £25,500 to £40,200 (NHS bands 6 and 7) while salaries for PWC are normally £18,700 – 21,800 (NHS band 4) and can move to higher levels depending on future responsibilities.

Salaries in the UK health system are typically less than salaries in Canada. In order to estimate cost of an IAPT team in Canada, an estimate of \$112,000 per year is used for a hospital psychologist, as a reference point (based on salaries in Ottawa at present).¹³³ Based on the ratios of salaries of PWP to high intensity therapists in the NHS, the salary for a PWP would be in the range of \$67,000 (approximately 60%). A team comprised of three high intensity therapists and 2 PWPs would incur salary costs of approximately \$460,000 per year and would be expected to serve an area with 27,800 population. Benefits and institutional overheads would be expected to add approximately 40% (assuming average benefits of approximately 33% and institutional overheads of 8%). These estimates would indicate that program cost per 1,000 persons would be approximately \$27,500. Training costs, which would be higher in earlier years, would add to this cost, but they could be considered a one-time investment associated with the introduction of the IAPT service. In future, education costs could be assumed by provincial governments, trainees or through cost sharing arrangements between employer and employee. Start up costs would be highly variable depending on whether or not the IAPT service was located in existing facilities or if new facilities were to be rented or constructed.

An estimate of annual operating costs for a series of IAPT programs covering the entire Canadian population would be \$962 million. As noted above, staff training and start-up costs would add to this estimate in the early years of the programs and would be highly variable based on choices to be made about the locations of training (universities for intensive care therapists and community college for psychological wellbeing counseling).

In any event these costs would be modest compared to potential benefits. A recent report on IAPT program results in the UK to the end of the 2011-2012 fiscal year documents persons treated, rates of completion, recovery and return to work by persons on disability when they entered the program.¹³² These data indicate that 45,000 persons have been able to go off disability and return to work (pg. 22). Since the total number treated to date has been approximately 1 million, these data are equivalent to a rate of 45 persons going off benefits for every 1,000 persons treated. The rate based on persons actually on disability benefits would be much greater. The report also anticipates reductions in NHS costs for other health services, reductions in hospital inpatient and outpatient utilization and prescription drugs by IAPT clients and reductions in costs from lost time at work.

IX.6 Summary

This section has discussed three types of models for enhanced access to psychologists care that are believed to be viable in the Canadian context. All of these models have the potential to produce considerable benefits in terms of cost effective care. Positive returns on investment will be realized, both in terms of improved health in the population and a reduction in the economic burden of mental illness and addiction. Since the economic burden appears to now be in the range of \$60 billion per year, there is great scope for major economic gains.

Each of the models has advantages in specific sectors, which will affect the potential for their uptake and the distribution of costs. We do not argue that the models will 'pay for themselves'. More money needs to be invested in mental health and it should not be a condition of such investment that it will be

neutral or cost saving in terms of existing expenditure. Instead, the main rationale should be improved health, an increase in rates of needed care and an overall increase in the cost effectiveness of care. On the other hand, the potential reduction in the monetary and non-monetary burden of mental illness is real and, although difficult to quantify, should not be ignored.

Primary collaborative care is the first model discussed. Bringing psychologists into the primary care team has great potential to improve the quality of care, effectiveness of care, professional collaboration and satisfaction. Considerable effort has been made over the last decade to understand the potential of collaborative primary care. Where collaborative mental health care has been included in primary care models, results are positive. There is no single model that stands out, however, but rather a number of models that have been developed in ways that are consistent with local conditions and provider practice styles. We discuss some key elements of these models in terms of how they should be funded, where services are to be delivered and the roles of psychologists in collaborative care. We believe the approach taken by the Premiers Council to the development of innovative primary care models is appropriate. That approach is to identify best examples and share knowledge between jurisdictions so that promising models can be expanded to provinces and health regions that are ready for them. This is best seen as a pragmatic, rather than an ideal, approach but it is consistent with the development of health services and the adoption of best practices in Canada to date.

The second model is fee-for-service. We estimate that fee-for-service care by private practice psychologists presently accounts for approximately \$950 million in expenditure annually. The fee-for-service model provides a valuable service for those who are able and willing to pay. It provides a private practice option for many psychologists, both those in full time private practice and those in part time private practice. The main concerns about this model are that the costs are disproportionately paid by patients and that out-of-pocket costs provide a barrier to access for many who could benefit from psychologists care.

There are compelling arguments that the distribution of costs in fee-for-service practice should change, with employers bearing a much greater share through their employee insurance plans. There are clear benefits for employers and insurance firms in doing so – in particular a reduction in the costs to employers through lost productivity and a decrease in disability claims paid by private insurers. The discussion above offers suggestions for increasing the rates and levels of private insurance coverage, including the elimination or reduction of measures that limit access, such as service limitations and the requirement for physician referrals.

There are no compelling arguments that suggest fee-for-service as a method for increasing public sector funding of psychologists services through departments of health. The trend in funding primary care practices, in particular, is moving away from fee-for-service to alternative funding models that allow greater flexibility in organizing and delivering a full range of interventions that benefit clients and patients.

The third model is based on the UK IAPT program. This model should be attractive to provinces that wish to scale up, quickly, the provision of psychological services. It rationalizes the roles of highly trained professionals and others who can provide less intensive care for the population that can benefit

from modest interventions or directed self-help programs. There is a considerable amount of information based on experience with the UK plan that provinces can access if they wish to explore the potential of adopting a similar plan adapted to the Canadian context.

Most importantly, the models, as explored, need not be exclusive. It is quite possible to adopt a number of variations on the primary care collaborative model across Canada, based on local requirements and practice styles. Collaborative primary care models should be expanded. A key aspect of this model is the increased role played by the client and the client's family. The models are, essentially, community-based, and build upon and utilize other appropriate mental health services. Fee-for-service can be expanded with greater funding from private insurers. IAPT models can also be adopted where there is a determination to do so. It is unlikely that any one jurisdiction would choose to implement all the possible variations. Yet, there is significant potential to adopt specific models to local cultures and funding environments.

X Observations and Recommendations

X.1 Observations

Access to mental health services for Canadians has been studied, repeatedly and extensively, with little substantive change. Evidence supporting the imperative for change has never been lacking, whether assessed by incidence, prevalence, disability, economic burden, or measures of quality of life. The impact on those with mental health disorders, their families, and their workplace is severe. Continuation of the current provision of mental health services without change -- even profound change -- defies logic and evidence. Perhaps no other health issue has been studied in greater detail, with more evidence for required reform, and the veritable need for fundamental reconsideration of issues of access and availability. Falling short of system reform and reallocation of resources and funding can be viewed only as failure in a nation characterized as providing universal access to needed care.

Too often, solace has been taken through the establishment of commissions and academic assessments of need. The work of dedicated experts, individually and collectively, has been important and has facilitated advances in many dimensions of caring for the mentally ill and unwell. There can be pride in the gradual, albeit incomplete, removal of the stigmatization of mental illness; however, there can be no pride in the ongoing absence of timely access to services that mitigate the gravity of the impact of mental illness.

This study has benefited, substantially, from the work of others. It has enabled convergence of quality and quantitative analyses, founded in national and international experience, of access to mental health services, leading to the development of options and models.

Key observations, by subsets of the study, are summarized, as follows:

Subset 01

The Issues

O.01.01

20% of Canadians face a mental health problem, annually, which can remain largely unresolved or treated with isolated pharmacological interventions.

O.01.02

Publicly funded services based largely on physician and hospital services are not adequate to address need.

O.01.03

Third party funded services are restricted frequently by artificial time and financial restraints.

O.01.04

The burden of mental health care surpasses public expenditure by an estimated 20-fold.

Subset 02

The Dilemma

O.02.01

The societal cost of mental illness in Canada is estimated to be \$50B; this is a silent crisis of increasing demand and unmet need.

O.02.02

The movement of mental health care from institutions to communities has not been matched with appropriate levels of community support.

O.02.03

Primary care physicians are, not infrequently, stymied by the inability to access referred mental health services for their patients.

O.02.04

Estimates of quality-adjusted life year measures indicate that psychological services fall well within thresholds often used to determine insurability.

O.03

The History

O.03.01

Throughout the evolution of public insurance for medical care in Canada there has been an unequivocal recognition of the importance of both mental and physical health. The Canada Health Act provides a framework for insuring the services of both physicians and other health providers. In practice, however, the trend has been to focus on hospital and physicians services and to narrow coverage for services by other health professionals.

O.03.02

Major studies carried out for the Government of Canada (Kirby and Romanow) have recommended greater attention to, and action to address, mental health challenges. Yet little progress has been made in translating their insights and recommendations into political action. The reasons are not clear but they could include:

- The concept of medical necessity, which underpins medicare coverage, is arguably easier to define in physical health than in mental health.

- Mental health is influenced by a wide range of medical, social and economic conditions. Champions of mental health tend to provide a broad range of options which may result in a set of diffused rather than closely focused recommendations. The latter are often more effective in influencing public policy.
- Cost control has been a major concern with governments since the 1980s. Cost restraint and retrenchment in the 1990s reduced hospital expenditure, including services for mental health.
- Reinvestment in the 2000s appears to have focused on traditional services and funding for a rapid growth in physician supply. Anecdotal evidence indicates that some hospital psychological services that were reduced during the cost restraint period have not been restored.
- The relative strength of provider groups should not be ignored. Physicians' associations are well organized and well placed to influence policy makers. Other provider representatives lack the political strength to influence policy and must rely on building compelling arguments and generating public support for their services. Good ideas, even when presented with compelling logic, may not resonate with policy makers unless they are convinced that policy action is necessary at a particular point in time.

O.03.03

Mental health stakeholder groups and health care providers have taken the initiative to study optimum modes of practice organization in order to promote collaboration and the integration of mental health services with medical care. We have summarized key findings from these initiatives that have the potential to strengthen the business case for including the services of psychologists and other mental health providers in publicly funded health care.

O.03.04

The recent report of the Mental Health Commission of Canada has added additional insight and the strength of a strong public consensus to improve Canadians' mental health. The Premiers Council Innovation Initiative provides a current policy making forum in which positive change can be effected, but mental health has not yet been identified as a priority for action.

S.04

Environmental Scan

O.04.01

The incidence and prevalence of mental health illness in Canada is very high; the annual economic burden of mental illness in Canada is estimated to be \$50B; the estimated lifetime economic cost of untreated childhood mental health disorders is estimated to be approximately \$200B in Canada.

O.04.02

Across public sectors, mental health services are characterized by significant unmet need, especially for those seeking care in the public system, as structured today.

O.04.03

Child and youth mental health services are a very significant unmet need that is responsible for increased acuity over time; one study revealed that only 1 in 6 children in need of mental health services is receiving care.

O.04.04

Independent academic research determined that the burden of mental illness, in terms of premature mortality and ill health, was 1.5 times the burden of all cancers and 7 times the burden of infectious diseases.

O.04.05

Independent academic research determined conditions associated with mental illness were responsible in Ontario for 867 deaths, 20,283 years of life lost due to premature mortality (YLL), and 603,722 health adjusted life years lost (HALY) in Ontario annually.

O.04.06

Disability from mental illness is the greatest cost centre for the private health insurance industry.

O.04.07

The largest single employer of psychologists in the country is Correction Services Canada; however, there is a high vacancy rate and a significant unmet need, in part due to uncompetitive compensation, a stressful workplace environment, misaligned areas of responsibility, and inconsistent opportunities for preparing for a career in forensic psychology.

O.04.08

Integrated and multidisciplinary care is fundamental to service expansion and enhanced access to mental health services; despite support for such care, there are no signals of expanded public coverage for psychologists' services.

O.04.09

There is an historical pattern of psychologists being bypassed in funding models for mental health services, underlined further by the absence of the restoration of hospital-based funding, following earlier service reductions.

O.04.10

In Canada, annual public funding for psychotherapy and counseling services exceeds \$300M for family physicians, despite the absence of specific training to provide such services, other than those services possibly provided by GP psychotherapists.

*S.05**Public Sector and Total Expenditures***O.05.01**

Estimates of mental health expenditure for fiscal 2007-2008 totaled \$14.3 billion, of which \$10.6 billion was for services and \$3.7 billion was for income support. These estimates include expenditure for physicians' services but they do not include estimates of expenditure for psychologists or other professionals.

O.05.02

Estimates of expenditure for private practice psychologists' services in the ten provinces totaled approximately \$950 million, equivalent to \$27.54 per capita. Quebec, Ontario and Alberta account for most expenditure with Quebec and Alberta having the highest expenditure per capita. These two provinces have the highest ratios of psychologists-to-population.

O.05.03

Private practice psychologists account for 4.6% of total expenditure in Canada on health care providers other than physicians. Private insurance data indicate that psychologists account for only 1.1% of private health insurance expenditure for health care providers.

O.05.04

Studies carried out for the MHCC estimate that approximately 10% of the economic burden of mental health is accounted for by medical costs, approximately 35% represents the value of lost productivity through time lost at work and 55% represents the cost of ill health to consumers in the form of reduced life expectancy and quality of life.

O.05.05

A recent study by the Conference Board of Canada estimates current costs of lost productivity due to mental illness at approximately \$21B per year – a figure that is consistent with the estimates for the MHCC adjusted for inflation.

S.06

Canadian Models

O.06.01

Collaborative primary care models that include psychologists have been well accepted where they have been established. For example, an analysis of experience in Ontario found that family physicians had high levels of satisfaction in their collaboration with mental health teams and found that it benefited their patients.

O.06.02

In another study, family physicians acknowledged that they did not receive sufficient training in medical school to address the mental health problems of their patients. They also reported that they were reluctant to refer patients to psychologists because of the cost to the patients.

O.06.03

Primary care practices in Alberta, in which mental health professionals provide patient consultations, report positive results. Physicians in the practice tended to prefer a model where the mental health professional conducted the assessment independently to a model where there was joint participation in the consultation session. This division of responsibility was seen as a way to make the best use of the time and expertise of each professional.

O.06.04

Specialist models involving physicians and psychologists have also reported positive results. These models include children's mental health care.

S.07

International Models

O.07.01

Both the UK and Australia have introduced major new programs to enhance mental health care during the last five years. Both programs provide public sector support for services by psychologists and other mental health care providers. The UK program is delivered by public sector agencies while the Australian program features fee-for-service reimbursement for services by psychologists, physicians, mental health nurses and social workers certified by their respective professional governing bodies.

O.07.02

The UK program (Improving Access to Psychological Therapies - IAPT) had expenditure per capita equivalent to C\$11.53 in 2010-2011 for the working age population. Total mental health expenditure in the UK that year for working age persons was equivalent to C\$307 per capita. IAPT results have been positive, with 1 million persons receiving services and close to 50% of treated cases proceeding to a

cure. The program, originally for working age adults, is being expanded to cover children and the elderly.

O.07.03

The Australian Better Access plan had expenditure per capita of \$23.31 in 2009-2010. Approximately 650,000 persons received insured services in 2010-2011, with an average of 5.2 services per person. Changes to the program announced in 2011 have capped insured services at 10 per year with up to an additional six services in cases of exceptional needs during a transitional period scheduled to end in 2012. Evaluations have been positive, suggesting the plan had met its goals of providing better access. An economic evaluation of psychologists services provided under the plan found they provided good value for money.

O.07.04

Although the UK and Australian plans are structured differently, they share a number of characteristics that can be considered success factors. These factors could be incorporated in programs to expand access to psychological therapies in countries with different cultures and systems of health care organization. The success factors include clear goals, reporting systems and indicators to evaluate progress. The roles of different types of providers are clearly defined and both patients and community organizations are recognized as important actors in the mental health environment.

O.07.05

The delivery and funding of psychology services are similar in the US and Canada. Private insurers play a major role in the US. There is concern that psychology services are undervalued in insurance coverage. Recent trends show a decrease in cognitive therapies and an increase in pharmaceutical therapy.

O.07.06

Medical professionals and psychologists share an interest in increasing collaborative primary care practice in the US. Collaborative practice has the potential to improve patient treatment. It also has the potential to be more cost effective than present approaches. There are barriers to establishing collaborative practice in the form of rigidities in both public and private insurance funding.

S.08

Economic Considerations

O.08.01

The business case for improved access to psychological services rests on two well established facts:

1. There is widely acknowledged need for increased mental health care. Approximately 14% of the population suffer from impaired mental health but are not receiving care.

2. Psychological services are a cost effective way to provide mental health care. There are ample academic studies to confirm this fact. Large natural experiments in the UK and Australia have demonstrated the cost effectiveness of psychological services on a population wide basis.

O.08.02

Provincial governments have accepted the proposition that there is a shortage of physicians in Canada and have made large investments in the last decade to increase the supply of Canadian trained physicians. A logical next step would be to engage members of other professions to provide care where they are uniquely capable of doing so. This is the case with psychologists and mental health care. Psychologists can provide more effective mental health care than family physicians and using psychologists as part of a collaborative team will free family physicians to concentrate on diagnosis and treatment of medical conditions.

O.08.03

Appropriate models of collaborative care can increase the effectiveness and the efficiency of both primary care in community based practices and secondary or tertiary care in institutional settings.

O.08.04

Public sector initiatives to treat more people who need health care at lower cost per patient will advance the objective of the Canada Health Act, which is, *to protect, promote and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health services without financial or other barriers*. It will do so in a way that is more sustainable than the present approach that relies on medical and pharmaceutical treatments of the symptoms of conditions that are more responsive to psychological therapies.

S.09

Models for Canada

O.09.01

It is important to recognize the structure of the present health system when recommending models for improved access, with a view to integrating new care models with existing ones in order to enhance patient centred care, and to minimize the necessity of new administrative structures in public systems.

O.09.02

The Canadian health care system includes a variety of delivery and funding models. This diversity is an important factor when recommending models for improved access. Accordingly, we have analyzed and suggested three major types of models, each with specific advantages in specific circumstances.

S.10

Collaborative Care Models

O.10.01

Provinces have committed to the expansion of collaborative primary care models. Although progress has been uneven, several provinces have made large investments in collaborative models that serve significant proportions of their populations.

O.10.02

The value of collaboration to improve mental health has been demonstrated and the principles that make these collaborations most effective have been documented. The medical profession, when given the chance to collaborate with psychologists, has expressed support and enthusiasm.

O.10.03

Collaborative primary care models have diverse structures. Participation of psychologists in these models should be guided by the characteristics of the existing practices and the needs of the population served, subject to certain considerations that will enhance the chances of successful collaboration.

O.10.04

The analysis has identified four key considerations for successful collaborative care models, both in primary care and specialist care. The roles of psychologists in these models include treatment, diagnosis and consultation, case management, and co-education with other health professionals.

S.11

Fee-for-Service Models

O.11.01

Fee-for-service private practice is well established in Canada, with expenditure of approximately \$950M per year. Rather than a publicly funded fee-for-service model, there are compelling arguments for providing more support for the cost of fee-for-service psychology through employer insurance.

O.11.02

Lost productivity resulting from mental illness and addiction costs employers an estimated \$20B per year. Mental health conditions account for the largest amount of insurer expense for disability insurance. There is considerable opportunity to recoup approximately one-third of these losses by implementing measures to prevent, diagnose, and treat mental illness. This will require strengthening employer insurance and dropping limiting conditions that reduce the scope of present insurance and impose often unaffordable costs on employees coping with mental health problems.

O.11.03

Discussion of enhanced fee-for-service insurance focuses on measures to effect change, including education of employers, public sector incentives in contracting with private sector firms for large projects and leadership in modifying the structure of public service employee insurance plans.

S.12

UK IAPT Model

O.12.01

Models based on the IAPT program in the UK could be used to scale up mental health services quickly in provinces that wish to do so.

O.12.02

IAPT programs rationalize the roles of psychologists as team leaders and providers of intensive therapy. Specially trained individuals provide non-intensive interventions. A system of stepped care is used, with non-intensive interventions as the first line of treatment for most conditions.

O.12.03

IAPT programs could be managed by RHAs with funding by provinces. Therapist training would be provided by universities and community colleges. Programs could be established incrementally, beginning with RHAs that have significantly underserved populations.

O.12.04

Delivery sites could be concentrated in existing practice environments, (such as mental health centres and hospital out-patient departments) allowing efficiencies in administration, professional collaboration and economies of scale in providing treatment.

X.2 Recommendations

Recommendations, in general, can be at risk of inaction. The following table lists variables that can influence action on any recommendation, and counterpoints that are applicable to this study.

HISTORIC VARIABLES	THIS STUDY
Insufficient evidence for action	Not true for access to mental health services
Insufficient support from stakeholders	Evidence of broad support for meaningful change
Climate for change is not favourable	When is the climate right?
Low capacity to develop or adopt models	Not true when there are many innovative models
Low priority	Possibly true ,with a legacy of wide support and insufficient action
Lack of leadership	No evidence of an organizational leadership vacuum, in addition to the Premiers' call for innovative solutions for achieving sustainable change
Lack of resources	Should not be an issue with reallocation of extant resources and the societal return on investment

Following are recommendations derived from the evidence of literature and qualitative and quantitative interpretations of the environmental scans. If accepted, the timing of implementing the recommendations will need to vary, and the diversity of stakeholders, each with unique interests and priorities, will necessitate strategic planning, sensitive to the rate and magnitude of change. That notwithstanding, underpinning the recommendations is clear evidence of resource allocations that require realignment with jurisdictional priorities and the needs of the populations served, and the unique role and value that can be provided by well trained psychologists.

Recommendation 1

That collaborative primary care models that include psychologists be an accepted fact in the evolution of collaborative care in Canada. Administrative structures and funding methods should be modified to recognize the importance of professional and client decision making and to eliminate bureaucratic rigidities. Incentives should be provided for best practices but only for verifiable excellence or innovation in improving patient outcomes.

Recommendation 2

That collaborative specialist care models be implemented in hospitals and other sites offering secondary and tertiary care for conditions where psychological services have been shown to improve patient outcomes, such as cardiac care and pain clinics.

Recommendation 3

That fee-for-service models continue to be the preferred funding method for insurers, social security funds (WCB and publicly funded liability insurance), and for individuals who prefer to use private practice psychologists' services.

Recommendation 4

That a greater share of the cost of private insurance be borne by employers that sponsor individual plans. These employers stand to realize potentially large gains from a reduction of lost time from work and a reduction in disability benefits due to work-related stress.

Recommendation 5

That insurance plans eliminate unnecessary restrictions on mental health services, which often interfere with optimum treatment regimens; and requirements for physician referrals, which pose unnecessary costs for patients and provincial medicare programs.

Recommendation 6

That programs based on the UK IAPT model be recommended to provinces that wish to adopt a comprehensive approach to mental health services. These programs can be managed by RHAs and be coordinated with existing community mental health services.

Recommendation 7

That provinces that wish to establish IAPT programs be encouraged to begin with RHAs that serve populations that are underserved in terms of mental health care. Additionally, the RHAs should have innovative leadership and be able to document and share results with their peers. Additional sites can be added incrementally, gaining from experience by pioneering sites.

Recommendation 8

That financial incentives be provided for IAPT models that excel in terms of innovative approaches and patient outcomes.

Recommendation 9

That CPA and its US counterpart, the APA, set up a liaison process to pool experience and, where possible, join forces to promote the adoption of evidence-based best practices in integrated primary care.

Recommendation 10

That CPA, physician groups, and other mental health stakeholders take the lead in promoting appropriate models of care for mental illness and addiction. The contributions of such models, as a way to improve mental health outcomes and the financial sustainability of publicly funded medicare, should be stressed. Recommendations should be advanced within the innovation agenda of the

Premiers Council of the Federation and acknowledge that it can be difficult to align the priorities of stakeholder groups. This reality should not deter action on the compelling evidence that leads to the imperative for change.

Recommendation 11

Staffing guidelines for the mix of professionals in collaborative care models should be developed by professional associations (e.g., CPA, College of Family Physicians).

Recommendation 12

That demonstration projects and randomized controlled trials of innovative models of mental health care be designed through a collaboration of CPA's Practice Directorate and Scientific Directorate. These projects should include practice guidelines where they exist. Other concerned groups such as the College of Family Physicians of Canada should be invited to participate. Funding for the projects should be sought from CIHR and provincial governments.

Appendix 1 - Environmental Scan

A.1.1 Common Introduction to Surveys

David Peachey of Health Intelligence Inc. (HII), in collaboration with Vern Hicks and Orvill Adams, have been asked to assist the Canadian Psychological Association in qualitative and quantitative analyses that examine models for access to and funding of psychologist services in Canada. This study is timely, considering the incidence and prevalence of mental health disorders in Canada and the challenges of access to required services. An increasing demand and need are unmet; a mental health disorder affects one in five Canadians with an annual societal cost estimated to be \$50 billion.

National and international literature will be reviewed in the context of an environmental scan of knowledgeable Canadian resources, representing different key sectors. This scan is underpinned by the attached survey; it will be greatly appreciated if you are able to participate through its completion.

Thank you very much for considering this; the survey has been structured to not impose significantly on your busy schedule.

If possible, we are hoping to receive your responses by October 19, 2012.

Please be advised that the survey results are confidential to the three consultants and will not be attributed in any way; the data will be collated by sector and without individual identifiers.

A.1.2 Common Conclusion to Surveys

Please add any comments that you believe are relevant to the issue(s), but were not included in the survey questions.

To reiterate, please be advised that the survey results are confidential to the three consultants and will not be attributed in any way; the data will be collated by sector and without individual identifiers.

If possible, we are hoping to receive your responses by October 19, 2012.

If you would like to supplement this confidential survey with a telephone discussion, please contact:

Dr. David Peachey at davidpeachey@healthintelligence.ca

A.1.3 Survey of Psychological Associations

Psychological Associations	
Question	Response
In which province or territory are you located?	
What is the number of licensed psychologists in your province or territory? How many licensed psychologists belong to your association?	
Is there a human resource plan in your province or territory that includes psychologists? If so, is the plan formal or informal? Are you able to share the plan with us?	
Which of the following funding sources are utilized by your membership in the provision of psychological services: a) Provincial or territorial government (Health) b) Provincial or territorial government (Children or Youth or Social Services) c) Private practice d) Federal Government e) Workers Compensation	
Approximately, what percentage of practising psychologists are primarily employed in the following sectors: a) Provincial or territorial government (Education, Corrections, Health) b) Children or Youth or Social Services c) Private practice d) Federal Government (Department of National Defence, Corrections, Veterans Affairs) e) Workers Compensation	
Is there a provincial or territorial fee schedule or billing guidelines for psychologists in private practice?	
Of the funding sources utilized, what are the limitations placed on access?	
What percentage of psychologist services in your province or territory are self-paid by individuals?	

<p>What estimates, if any, do you have regarding the level in your province or territory of unmet need in the provision of psychologist services?</p>	
<p>Is there any suggestion of expansion of any funding source for supporting the provision of psychologist services in your province or territory?</p>	
<p>Please describe the nature of integrated, primary health care teams that involve psychologists in your province or territory.</p>	
<p>What is your assessment of the level of unmet need in the provision of psychologist services?</p>	

A.1.4 Survey of Provinces and Territories - Health

Government - Health	
Question	Response
Part A	
Does your Ministry or Department provide public funding (through a government department or agency) for psychologist services? If not, please go to Part B.	
Approximately, for how many persons and at what level of funding does your Ministry or Department provide public funding for private psychologist services? Are any of these psychologists salaried employees of the Ministry or Department?	
How does your Ministry or Department define licensed psychologist for the purpose of establishing eligibility for coverage?	
Does the funding include services provided by private practice psychologists?	
Does the presence or absence of integrated, primary health care teams determine the nature and level of coverage for psychologist services?	
What is your assessment of the level of unmet need in the provision of psychologist services?	
Part B	
Are there considerations in your Ministry or Department to reassess public coverage for psychologist services?	
What are the barriers in your Ministry or Department to achieving public coverage for psychologist services?	
What is your assessment of the level of unmet need in the provision of psychologist services?	
Would the presence or absence of integrated, primary health care teams influence the nature and level of coverage for psychologist services?	

A.1.5 Survey of Provinces and Territories - Children or Youth Services

Government - Children or Social Services	
Question	Response
Part A	
Does your Ministry or Department provide public funding (through a department or agency) for psychologist services? If not, please go to Part B.	
Approximately, for how many persons and at what level of funding does your Ministry or Department provide public funding for private psychologist services? Are any of these psychologists salaried employees of the Ministry or Department?	
How does your Ministry or Department define licensed psychologist for the purpose of establishing eligibility for coverage?	
Does the funding include services provided by private practice psychologists?	
Does the presence or absence of integrated, primary health care teams determine the nature and level of coverage for psychologist services?	
What is your assessment of the level of unmet need in the provision of psychologist services?	
Part B	
Are there considerations in your Ministry or Department to reassess public coverage for psychologist services?	
What are the barriers in your Ministry or Department to achieving public coverage for Psychologist services?	
What is your assessment of the level of unmet need in the provision of psychologist services?	
Would the presence or absence of integrated, primary health care teams influence the nature and level of coverage for psychologist services?	

A.1.6 Survey of Federal Government

Federal Government	
Question	Response
Part A	
Does any department or agency of the federal government provide public funding for psychologist services? If not, please go to Part B.	
Approximately, for how many persons and at what level of funding does your Ministry or Department provide public funding for psychologist services?	
How does your Ministry or Department define psychologist for the purpose of establishing eligibility for coverage?	
Does the funding include services provided by private practice psychologists?	
Does the presence or absence of integrated, primary health care teams determine the nature and level of coverage for psychologist services?	
What is your assessment of the level of unmet need in the provision of psychologist services?	
Are you able to provide us with the departmental contacts so that we can survey them, as well?	
Part B	
Are there considerations in your Ministry or Department to reassess public coverage for psychologist services?	
What are the barriers in the federal government to achieving public coverage for psychologist services?	
What is your assessment of the level of unmet need in the provision of psychologist services?	
Would the presence or absence of integrated, primary health care teams influence the nature and level of coverage for psychologist services?	

A.1.7 Survey of Private Insurers

Private Insurers	
Question	Response
Part A	
Does your company insure supplementary health benefits? If not, please go to Part B.	
Does your company provide a full range of supplementary hospital and extended health benefits (EHB)? (EHB can include some or all drugs, dental care, out-of-country insurance, health professionals, and products such as eye glasses, hearing aids, and prosthetics)	
Approximately, how many persons does your company cover for EHB?	
Approximately, what was the amount of the total hospital and EHB claims payments by your company, in the most recent year for which data are available (please specify year)?	
Approximately, what was the amount of the total claims payments by your company in the most recent year for which data are available for services provided by health professionals, namely dentists, optometrists, chiropractors, and psychologists?	
Does your company insure services provided by private practice psychologists? If yes, is the coverage of services provided by private practice psychologists included in your standard EHB portfolio or as an add-on benefit available at the request of the employer? Do you insure the services of psychologists as part of individual EHB plans?	
How does your company define psychologist for the purpose of establishing eligibility for coverage?	
Approximately, what was the amount of the total claims payments by your company in the most recent year for which data are available for services provided by psychologists?	
Does your company have limits on the amount of benefits per individual or family for psychologist services?	

<p>Do the amounts specified above include Administrative Services (ASO) plans?</p> <p>If not, what was the total paid in benefits by your company in the most recent year for which data are available for ASO benefits?</p>	
<p>Does your company foresee any possible changes in the coverage of psychologist services in the next three years?</p> <p>If yes, what are the changes under consideration?</p>	
<p>Do you have data that link the use, or absence of use, of psychological services and disability claims related to mental health?</p> <p>Is there evidence that persons with mental health long-term disability are more or less likely to have access to psychological services through EHB?</p>	
<p>Part B</p>	
<p>Does your company foresee the inclusion of psychologist services as a standard benefit of your group EHB plans in the next three years?</p>	
<p>Does your company foresee the inclusion of psychologist services as a standard benefit of your individual EHB plans in the next three years?</p>	
<p>Does your company foresee limits on the amount of benefits per individual or family for psychologist services?</p> <p>If so, what is the nature of the limits being considered?</p>	

A.1.8 Survey of Workers’ Compensation Boards

Workers’ Compensation Boards	
Question	Response
Part A	
Does your organization provide funding for psychologist services? If not, please go to Part B.	
Approximately, for how many persons and at what level of funding does your organization provide funding for psychologist services?	
How does your organization define psychologist for the purpose of establishing eligibility for coverage?	
Does the funding provided by your organization include services provided by private practice psychologists? If yes, do you negotiate fees on a per service basis or use other criteria to determine the level of reimbursement (please specify)?	
Does the presence or absence of integrated, primary health care teams determine the nature and level of coverage by your organization for psychologist services?	
Does your organization have limits on the amount of benefits per individual for psychologist services?	
What is your assessment of the level of unmet need in the provision of psychologist services?	
Part B	
Does your organization foresee the inclusion of psychologist services as a standard benefit in the next three years?	
Does your organization foresee limits on the amount of benefits per individual or family for psychologist services? If so, what is the nature of the limits being considered?	
What is your assessment of the level of unmet need in the provision of psychologist services?	

Appendix 2 - Estimation of Expenditure for Private Practice Psychologists

Estimates were prepared using two sources of information: (1) a survey of provincial psychological associations developed by consultants and distributed by CPA; (2) a 2010 membership survey in Alberta carried out by academics at the University of Calgary and the Psychologists Association of Alberta (PAA), which was used to determine key variables relating to financial aspects of practice. The variables and source of each are shown in the table below.

Variables used in the estimation model and source of information

Provincial Associations Survey	Alberta Membership survey
Registered psychologists	
Number or Percent in private practice	
	Average hours
	Percent billable hours
	Private practice net income
Published hourly fee	Average (effective) hourly fee

Two methods were used to estimate expenditure in each province. In the first method, an estimate of average expenses of practice (35%) (based on previous studies of physicians overhead expenses by the consultants), was used in conjunction with average net income to calculate average gross income in Alberta during 2010. The number of psychologists in private practice and average gross income were used to estimate total expenditure in Alberta. In other provinces, the Alberta gross income estimates were adjusted by the ratio of published hourly fees in that province to published hourly fees in Alberta.

In the second method, the number of private practitioners was multiplied by average hours, percent billable hours and average hourly fee. In provinces other than Alberta, the average fee was estimated by multiplying the published hourly fee by the ratio of average fee to published fee in Alberta. The result was multiplied by 44 weeks to determine annual expenditure.

In Quebec the numbers of psychologists in private practice were available from the Annual Report of the L'Ordre des psychologues du Quebec. The Quebec data included full time and part time private practice. Total private practice was estimated by adding one-half the number in part time practice to the number in full time practice. Psychologists employed in CLSCs were not included in the number of private practitioners. In Ontario the number in private practice was equal to the number employed in group and solo practice in statistics from the Ontario College of Psychologists. The College data reported 3,378 psychologists, representing the number authorized to provide psychological services and excluding academic psychologists and those who are retired or inactive. Data from the OPA indicated that there were 369 psychologists employed in universities. Other provinces appeared to

report academic psychologists in their data. As a result of these reporting conventions, the ratio of private practitioners to licensed psychologists in Ontario appears to be higher than normal.

In one province the number of registered psychologists estimated by the provincial association appeared to be a rough approximation and was less than the actual number reported by CIHI in 2009, which was used instead³⁴.

Two provinces did not provide estimates of the number or percent of private practitioners. An estimate of 35% was used for those provinces.

Estimates from the two methods were very close, with differences of less than two percent in all provinces except Quebec. Quebec did not provide an hourly fee but instead showed the fee paid by a provincial government agency, which was well below published fees in other provinces. Average income in Quebec in method 1 was determined by multiplying the Alberta average income by the ratio of average incomes for full time equivalent physicians in the two provinces, on the assumption that there would be some similarity in relative income differentials based on provincial economic and market conditions. The provincial agency fee was used in method two. The difference between the two estimates was 15%, with method 1 higher than method 2.

Estimates from method 1 were used in the report. A spreadsheet showing the results of estimates for each province has been submitted to CPA with this report.

Appendix 3 - Reference

- ¹ Roberts, G. and Grimes, K. (2011). Return on Investment. Mental Health Promotion and Mental Illness Prevention. Canadian Policy Network (CPNET) and Canadian Institute of Health Information (CIHI)
- ² Moulding R, Grenier J, Blashki G, Ritchie P, Pirkis J, Chomienne M-H. Integrating psychologists into the Canadian health care system: the example of Australia. *Can J Public Health* 2009; 100(2): 145-47
- ³ Grenier J. Collaboration between family physicians and psychologists: what do family physicians know about psychologists' work? *Can Fam Physician* 2008; 54(2): 232-233
- ⁴ Canada's Health Care Providers, 2000 to 2009: A Reference Guide. CIHI, Ottawa, <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1661>
- ⁵ Canada Health Act (R.S.C., 1985, c. C-6). Current to 2012-08-19 and last amended on 2012-06-29. Department of Justice. Government of Canada. <http://laws-lois.justice.gc.ca/eng/acts/C-6/>
- ⁶ The Health of Canadians – The Federal Role. The Standing Senate Committee on Social Affairs, Science and Technology. Ottawa, 2002. (Recommendations). <http://www.parl.gc.ca/Content/SEN/Committee/372/soci/rep/repoct02vol6highlights-e.htm>
- ⁷ Building on Values: The Future of Health Care in Canada. Commission on the Future of Health Care in Canada. Romanow, RJ. Ottawa. 2002.
<http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>
Recommendations in Brief.
<http://www.hc-sc.gc.ca/hcs-sss/com/fed/romanow/recomm-eng.php>
- ⁸ National Health Expenditure Trends 1975 to 2012. Canadian Institute for Health Information. Ottawa. 2012. Supplementary Table C.3.1
- ⁹ Ibid. Supplementary Table F.1.1.4
- ¹⁰ <http://www.ccmhi.ca/en/index.html>
- ¹¹ Canadian Collaborative Mental Health Initiative Final Report. May 2006. <http://www.ccmhi.ca/en/our/documents/FinalReport-May2006.pdf>
- ¹² CCMHI Provincial Consultations (Nova Scotia, Manitoba, Saskatchewan) Final Report. January 2008. <http://www.ccmhi.ca/en/our/Phase2.htm>
- ¹³ The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care. EICP Steering Committee Report. Conference Board of Canada. September, 2006. <http://www.eicp.ca/en/principles/sept/EICP-Principles%20and%20Framework%20Sept.pdf>
- ¹⁴ John Service, Chair of EICP Steering Committee. Personal correspondence. August, 2012
- ¹⁵ Which Doors Lead to Where? How to Enhance Access to Mental Health Service: Barriers, Facilitators and Opportunities for Canadians' Mental Health. Mental Health Table Forum Report. Ottawa, 2010.
- ¹⁶ Project IN4M: Integrating Needs for Mental Wellbeing into Human Resource Planning Final Report. March 2011. http://www.cpa.ca/docs/File/Publications/Project_IN4M-FINAL_REPORT.pdf

- ¹⁷ Mental Health Commission of Canada. Vision and Mission. <http://www.mentalhealthcommission.ca/English/Pages/TheMHCC.aspx>
- ¹⁸ Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada. The Standing Senate Committee on Social Affairs, Science and Technology. May, 2006. <http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/rep02may06-e.htm>
- ¹⁹ Changing directions, changing lives: The mental health strategy for Canada. Mental Health Commission of Canada. (2012). Calgary, AB. <http://strategy.mentalhealthcommission.ca/>
- ²⁰ Note for financial analysis - estimates of 7% of annual health expenditure in Canada compared to 10% to 11% in NZ and the UK (p.126].
- ²¹ From Innovation to Action: The First Report of the Health Care Innovation Working Group. Premiers Council of the Federation. 2012. <http://www.councilofthefederation.ca/pdfs/Health%20Innovation%20Report-E-WEB.pdf>
- ²² National Physician Database (NPDB); Canadian Institute for Health Information, 2009-2010 data release
- ²³ National Health Expenditure Database (NHEX); Canadian Institute for Health Information, updated November 9, 2012
- ²⁴ 70% of public service psychologists are employed by CSC
- ²⁵ This would equate to approximately 3.5 hours of psychologist services, annually
- ²⁶ Specifically in the context of family physicians who provide “psychotherapy” with minimal or no training in this area; does not include Psychiatrists or GP Psychotherapists
- ²⁷ Globe and Mail, November 3, 2012, letter to the editor from the Chief Psychiatrist at the Hincks-Dellcrest Centre for Children and Families
- ²⁸ New York Times, November 18, 2012, p. 24
- ²⁹ Globe and Mail, October 30, 2012, by Chair of the Mental Health Commission of Canada and senior medical advisor at Toronto’s Centre for Addiction and Mental Health
- ³⁰ Globe and Mail, November 12, 2012, p.1
- ³¹ U.S. Department of Health & Human Services; Agency for Healthcare Research and Quality, January 2012 Feature story
- ³² As well, provincial service and payment databases were examined for the last fiscal year, where available, and confirmed the same current trends in the provision of mental health services by family physicians
- ³³ Hospital Mental Health Services in Canada, 2009–2010. Canadian Institute for Health Information. Ottawa. 2012. https://secure.cihi.ca/free_products/Mental%20Health%20Annual%20Report%202009-2010%20FY_2012_EN-web.pdf
- ³⁴ National Health Expenditure Trends, 1975 to 2012. Canadian Institute for Health Information. Ottawa. 2012
- ³⁵ Jacobs P, Dewa C, Lesage A, Vasiliadis H, Escobar C, Mulvale G, Yim R, (2010). The cost of mental health and substance abuse services in Canada. Edmonton, AB: Institute of Health Economics
- ³⁶ Ibid, page 2

- ³⁷ Petrovic-Poljak A, Keith A, Dobson A, Berube P. Professional Psychology in Alberta: The 2010 Survey of Employment, Salaries and Workforce Issues. University of Calgary and Psychologists' Association of Alberta.
- ³⁸ Quebec Psychological Association. http://www.ordrepsy.qc.ca/pdf/Rapport_annuel_OPQ_2011_2012.pdf
- ³⁹ In Quebec and Ontario the data were comprehensive in that distributions by type of practice included all licensed psychologists. In Alberta the percentage in private practice was taken from the 2010 membership survey. In other provinces percentages in specific forms of remuneration often did not add to 100%.
- ⁴⁰ By convention, health professionals engaged in practices where resources are owned and decisions about terms of employment are made by the practitioners are considered to be in private practice. Some primary care practices funded by contract (including FTE salaries) or capitation might seem to blur the lines of this definition, but it remains useful to distinguish between persons employed by government or private sector organizations and independent practitioners funded by those bodies.
- ⁴¹ Changing Directions, Changing Lives: The Mental Health Strategy for Canada. Mental Health Commission of Canada. Ottawa, 2012
- ⁴² Ibid, page 125
- ⁴³ Lim K, Jacobs P, Ohinmaa A, Schopflocher D, Dewa CS (2008). A new population-based measure of the economic burden of mental illness in Canada. *Chronic Diseases in Canada*, 28 (3), 92-98
- ⁴⁴ Canadian Economists have been in the forefront of the movement to develop measures of the quality of life and the cost of losses in utility measured through QALYs. The authors of the report cited are members or associates of the Institute of Health Economics at the University of Alberta, which has considerable experience in these methodologies.
- ⁴⁵ National Health Expenditure Trends, 1975 to 2012. Canadian Institute for Health Information. Ottawa. 2012
- ⁴⁶ Mental Health Issues in the Labour Force: Reducing the Economic Impact on Canada. Conference Board of Canada, Ottawa. 2012. <http://www.conferenceboard.ca/e-library/abstract.aspx?DID=4957>
- ⁴⁷ Ratnasingham S, Cairney J, Rehm J, Manson H, Kurdyak PA. Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addictions Report. An ICES/PHO Report. Toronto: Institute for Clinical Evaluative Sciences and Public Health Ontario; 2012
- ⁴⁸ Ibid, exhibits 3.5 and 3.6 on pages 26 and 27
- ⁴⁹ Ibid, page 7
- ⁵⁰ Doughty, 2006
- ⁵¹ Fleury et al, 2012
- ⁵² Grenier, 2008
- ⁵³ Farrar, 2001
- ⁵⁴ Ibid
- ⁵⁵ See Grenier
- ⁵⁶ See Fleury
- ⁵⁷ See Fleury

- ⁵⁸ Birnie, 2012
- ⁵⁹ Flessati, 2012
- ⁶⁰ Canadian Senate Committee on Social Affairs, Science and Technology 2006; Whalen, 2008
- ⁶¹ CIHI, 2006
- ⁶² Ministry of Health and Long Term Care, 2010. "The recovery approach changes the role of the service provider from expert to coach or partner, and the role of the person from patient to partner. In the journey towards recovery the individual gradually takes more and more control over his or her progress and health"
- ⁶³ Mental Health Commission of Canada, 2009
- ⁶⁴ Sarah Hamid-Balma ed., 2008
- ⁶⁵ CIHI, 2009
- ⁶⁶ Mental Health Commission of Canada, 2009
- ⁶⁷ London School of Economics and Political Science. Centre for Economic Performance, Mental Health Policy Group 2006) The depression report: a new deal for depression and anxiety disorders. Centre for Economic Performance, London School of Economics and Political Science, London, UK. <http://eprints.lse.ac.uk/818/>
- ⁶⁸ Improving Access to Psychological Therapies Implementation Plan: National guidelines for regional delivery. Dept. of Health. 2008.
- ⁶⁹ Clark, DM. Developing and Disseminating Effective Psychological Treatments: Science, Practice and Economics. Address given to the CPA Annual Convention. 2012.
- ⁷⁰ Investment in mental health: working age adult and older adult reports. Department of Health, UK. Aug. 2012. <http://www.dh.gov.uk/health/2012/07/investment-mental-health/>
- ⁷¹ The terminology used in the report may seem ambiguous at times to a Canadian, since the label, 'investment', might be interpreted here as including only spending on capital, infrastructure or training whereas it includes these program components plus direct benefit expenditures. This can lead to misinterpretations when new programs are being announced or expanded.
- ⁷² The 2011/12 National Survey of Investment in Mental Health for Older People. Dept. of Health. UK. August, 2012 (p. 30-31)
- ⁷³ A full list of services is included in a breakdown of total expenditure in Appendix 3 of the 2011/12 expenditure report (pages 36 & 37)
- ⁷⁴ Between April 2010 and March 2011 the UK Pound fluctuated in value between \$1.49 and \$1.62 Cdn. A median rate of \$1.55 has been used in the comparisons discussed here. \$1.55 is also the approximate rate of exchange as of October, 2012
- ⁷⁵ The report describes the data and reporting process, as follows: 'The analysis is derived from the detailed financial files completed by PCTs, Mental Health Trusts and Local Authorities and then submitted to Mental Health Strategies (MHS) by Local Implementation Teams (LITs).' (pg. 3)
- ⁷⁶ IAPT website. <http://www.iapt.nhs.uk/about-iapt/>
- ⁷⁷ IAPT website. <http://www.iapt.nhs.uk/cyp-iapt/>

- ⁷⁸ Talking therapies: A four-year plan of action. Department of Health. UK Government Publications. 2011. <http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-of-action.pdf>
- ⁷⁹ The planned expansion to seniors is discussed in 'Talking Therapies', (Reference 8, Pg. 9 & 10)
- ⁸⁰ Summarized from the IAPT website (referenced above) on October 17, 2012.
- ⁸¹ Denman C. (2007). The organization and delivery of psychological treatments. *International Review of Psychiatry*, 19(1): 81-92
- ⁸² Richards, DA. Borglin, G. (2011). Implementation of psychological therapies for anxiety and depression in routine practice: Two year prospective cohort study. *Journal of Affective Disorders* 133 (2011) 51-60.
- ⁸³ Mind Charity. London, 2011. We Need to Talk: Getting the right therapy at the right time.
- ⁸⁴ How Mental Illness Loses Out In The NHS. Centre for Economic Performance. London School of Economics. London. June 2012. <http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf>
- ⁸⁵ No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages. U.K. Department of Health, London. Feb. 2011. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766
- ⁸⁶ No health without mental health: implementation framework. Department of Health. UK Government publications. <http://www.dh.gov.uk/health/2012/07/mentalhealthframework/>
- ⁸⁷ A list of individuals on the Working group and their affiliations, as well as the numerous stakeholders that contributed, is contained on page 53 of the report. It provides a snapshot of the many organizations that are active in mental health or support of mental health in the U.K.
- ⁸⁸ In the present transition 'GP Commissioning Groups' are expected to assume many of these responsibilities.
- ⁸⁹ Mental health services—in brief 2011. Australian Institute of Health and Welfare 2011. HSE 113. Canberra: AIHW.
- ⁹⁰ The Canadian dollar was valued at approximately 1 Australian dollar in July 2008. It fluctuated up to 1.2 and down to 0.98 Aus dollars during the 2008-09 fiscal year (with much of this volatility likely due to the recession). During 2010 and 2011 the Cdn dollar ranged in value from 5% to 10% below the Aus dollar. As of Oct. 5, 2012 the two currencies were equal in value (source: Bank of Canada).
- ⁹¹ National Action Plan on Mental Health 2006-2011. Council of Australian Governments. Canberra, 2006.
- ⁹² www.health.gov.au/mentalhealth-betteraccess
- ⁹³ Better Access to Psychiatrists, Psychologists & GPs through the MBS. <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba>
- ⁹⁴ <http://www.psychology.org.au/medicare/faqs/>
- ⁹⁵ Mental Health Services in Australia. Australian Institute of Health and Welfare. Council of Australian Governments. <http://mhsa.aihw.gov.au/home/>
<http://mhsa.aihw.gov.au/additional/archived/>
- ⁹⁶ Fact sheet: New transition arrangements for the allied mental health services available under the Better Access initiative. <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-ba-fact-transfac>

- ⁹⁷ An evaluation of the Better Access Plan data (discussed below) showed that over 90% of claims by psychologists and allied health providers were for sessions lasting over 50 minutes (pg. 39).
- ⁹⁸ APS 2012-2013 Schedule of recommended fees - 1 July 2012 to 30 June 2013 http://www.psychology.org.au/community/fees_rebates/
- ⁹⁹ Medicare Benefits Schedule - Note M7.1. <http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=M7.1&qt=noteID&criteria=focused%20psychological%20strategies>
- ¹⁰⁰ This statistic is from a 2011 evaluation report, discussed below
- ¹⁰¹ Mental Health Services in Australia. Data Sources section. <http://mhsa.aihw.gov.au/resources/expenditure/data-source/>
- ¹⁰² Australia health service delivery profile. World Health Organization. Geneva. July 2012.
- ¹⁰³ It is also worth noting that where there is a choice between claiming reimbursement from a public plan supported by taxation and private insurance supported by experience rated premiums, there is an unambiguous incentive for consumers to choose the public source and for insurers to encourage this choice.
- ¹⁰⁴ Australian Psychological Society. Federal Budget cuts to the Better Access initiative. June 2011. <http://www.psychology.org.au/Assets/Files/07062011Better-Access-cuts-Briefing-Paper.pdf>
- ¹⁰⁵ Changes to Better Access. Butler, M. Minister for Health and Ageing. Feb. 1, 2012. <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr12-mb-mb005.htm?OpenDocument&yr=2012&mth=02>
- ¹⁰⁶ Government of Australia. Budget Paper #2, Part 2. http://www.budget.gov.au/2012-13/content/bp2/html/bp2_expense-12.htm
- ¹⁰⁷ The Crickey Health Blog. Sept. 26, 2012. <http://blogs.crikey.com.au/croakey/2012/05/09/mental-health-and-the-federal-budget/>
- ¹⁰⁸ Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative. Purkis J, Harris M, Hall W, Fatanou. The University of Melbourne. Melbourne Australia, February 2011.
- ¹⁰⁹ Giese J, Lindner H, Forsyth C, Lovelock H. Survey of clients receiving Medicare-funded psychological services under Better Access initiative. Psych 2008;30(4):32-33.
- ¹¹⁰ Jorm AF. 2011. Australia's Better Access Initiative: Do the Evaluation Data Support the Critics? Aust N Z J Psychiatry Vol. 45 no. 9 700-704.
- ¹¹¹ American Psychological Association. Center for Workforce Studies. <http://www.APA.org/support/about/psych/numbers-us.aspx#answer>
- ¹¹² AHRQ defines the institutionalized population as those residing in health facilities or non-health facilities. Health facilities include nursing homes or other long-term care facilities, but not community hospitals. Non-health facilities include homes for juvenile delinquents, jails, and prisons. (MEPS Household Component Study Glossary, pg. 46, 47). http://meps.ahrq.gov/mepsweb/survey_comp/hc_ques_glossary.pdf

- ¹¹³ Agency for Healthcare Research and Quality. Agency News and Notes. November, 2009. <http://www.ahrq.gov/research/nov09/1109RA21.htm>
- ¹¹⁴ Brown E. Health Care Expenditures for Adults Ages 18-64 with a Mental Health or Substance Abuse Related Expense: 2007 versus 1997. Statistical Brief 319. Agency for Healthcare Research and Quality. http://meps.ahrq.gov/mepsweb/data_stats/Pub_ProdResults_Details.jsp?pt=Statistical%20Brief&opt=2&id=994.
- ¹¹⁵ Experts call for integrating mental health into primary care. Agency for Healthcare Research and Quality. Research Activities. January 2012. <http://www.ahrq.gov/research/jan12/0112RA1.htm>
- ¹¹⁶ Nordal K.C. 2010. Where has all the psychotherapy gone? American Psychological Association Monitor on Psychology. 41(10), 17. <http://www.APA.org/monitor/2010/11/perspectives.aspx>
- ¹¹⁷ Akincigil, A, Olfson, M, Walkup, JT, Diagnosis and treatment of depression in older community-dwelling adults: 1992-2005. Journal of the American Geriatrics Society 59(6), pp. 1042-1051, 2011.
- ¹¹⁸ Agency for Healthcare Research and Quality. Research Activities. March 2012. <http://www.ahrq.gov/research/mar12/0312RA33.htm>.
- ¹¹⁹ Derksen, J.J.I. (2009) Primary care psychologists in the Netherlands: 30 years of experience. Professional Psychology: Research and Practice. Vol 40(5), Oct 2009, 493-501.
- ¹²⁰ National Occupational Health and Safety Program; National Occupational Health Services Program; National Program for Science Policy.
- ¹²¹ Rintala-Rasmus, A, Elo, AI, Leppänen, A. Work and Organizational Psychology in Finland. Society for Industrial and Organizational Psychology. <http://www.siop.org/tip/jan11/13thompson.aspx>
- ¹²² L. Friedli, L., Parsonage M., "Building an Economic Case for Mental Health Promotion: Part I," Journal of Public Mental Health 6, 3 (2007): pp. 14-23.
- ¹²³ Roberts R, Grimes K. Return on Investment—Mental Health Promotion and Mental Illness Prevention. Canadian Institute for Health Information and the Canadian Policy Network at the University of Western Ontario. CIHI. Ottawa 2011
- ¹²⁴ Knapp M,, McDaid D,, Parsonage M (editors). *Mental Health Promotion and Prevention: The Economic Case*. London School of Economics and Political Science. London. 2011.
- ¹²⁵ Hunsley, J. THE COST-EFFECTIVENESS OF PSYCHOLOGICAL INTERVENTIONS. Canadian Psychological Association, Ottawa. 2002.
- ¹²⁶ McDaid, D. MAKING THE LONG-TERM ECONOMIC CASE FOR INVESTING IN MENTAL HEALTH TO CONTRIBUTE TO SUSTAINABILITY. Written under an IMPACT contract to support the European Pact for Mental Health and Wellbeing. European Union, 2011.
- ¹²⁷ *Investing in emotional and psychological wellbeing for patients with long-term conditions*. Mental Health Network, The NHS Confederation. London. 2012. <http://www.nhsconfed.org/publications>
- ¹²⁸ Allin, S. The Canadian Health Care System 2012. International Profiles of Health Care Systems, 2012
- ¹²⁹ National Institute for Health and Clinical Excellence. *Promoting mental wellbeing at work: business case*. London: NICE.2009. <http://www.nice.org.uk/nicemedia/live/12331/46023/46023.PDF>.
- ¹³⁰ NHS Careers Website: <http://www.nhs.uk/explore-by-career/psychological-therapies/psychological-wellbeing-practitioner/>

¹³¹ 6,000 therapists for a working age population of approximately 33.4 million. The IAPT program is presently expanding to include the elderly and children. Using the same supply projection would result in a higher ratio of population to therapist would be higher.

¹³² Clark, David M. Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, August 2011; 23: 375-384. <http://www.iapt.nhs.uk/silo/files/clark-2011-implementing-nice-guidelines-the-iapt-experience.pdf>

¹³³ http://www.glassdoor.com/Salary/The-Ottawa-Hospital-Psychology-Salaries-E116113_D_KO20,30.htm

¹³⁴ *Canada's Health Care Providers, 2000 to 2009—A Reference Guide*. Canadian Institute for Health Information. Ottawa, 2011.