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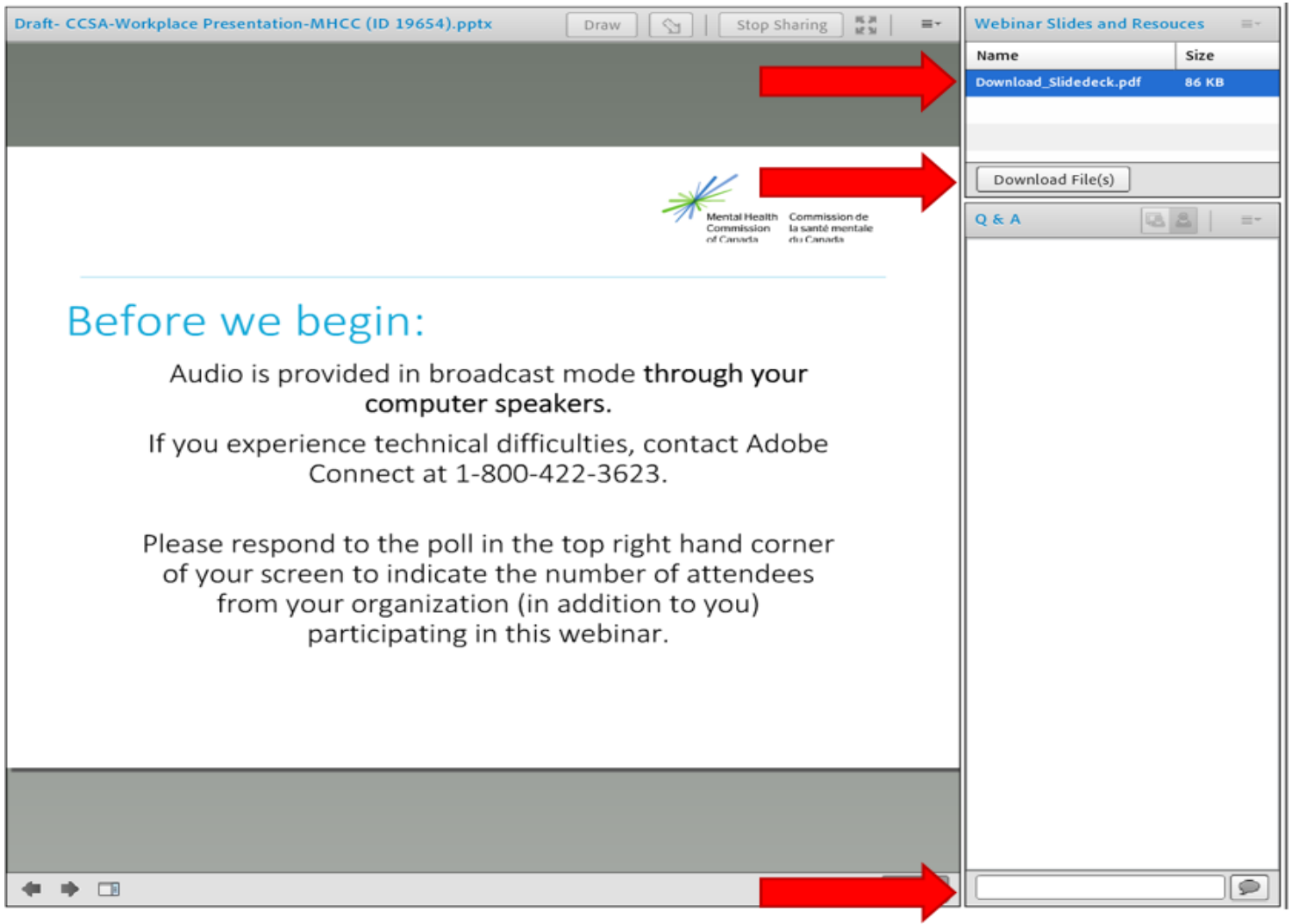

Commission de la santé mentale du Canada
Mental Health Commission of Canada

Expanding Access to Psychotherapy: Mapping Lessons Learned from Australia and the United Kingdom to the Canadian Context

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

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Prepared for the Mental Health Commission of Canada
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Why is this analysis important?

- Exclusion of allied mental health professionals from public insurance in Canada has contributed to:
  - Highest rates of unmet need for psychotherapy*
  - Greater financial barriers for 12M Canadians without employment-based benefits
  - Only 5-7% of health spending for mental health
- Facing similar challenges, Australia and the UK have introduced major reforms
- $5B federal transfer opens new window for reform in Canada

*Psychotherapy refers to mental health counselling and various psychotherapies and psychological services.

What is the purpose of this analysis?

- To support dialogue and evidence-informed decision-making regarding expanded access to psychotherapy in Canada…
- … by mapping lessons learned from the implementation of reforms in Australia and the UK onto the Canadian context.
- Sources:
  - MHCC 2017 background paper/roundtable, academic and policy literature, experts in the UK and Australia, senior provincial and territorial officials in Canada

Australian model – Better Access

- Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule launched in 2006
  - Response to survey showing 2/3 Australians with mental disorders not accessing treatment
  - Insurance-based, added allied mental professionals to federal Medicare
  - Complemented by smaller federal investments
  - Workforce quality assured by regulated by professional associations
  - 2011 evaluation main source of performance monitoring
  - Currently expanding telehealth to improve reach in rural areas

UK model - IAPT

- Improving Access to Psychotherapies launched in 2008 in England
  - Response to NICE guidelines and business case re adults with mild to moderate depression and anxiety
  - Grant-based, centrally-administered by NHS
  - Explicit stepped care
  - IAPT workforce purpose-built
  - Clear targets backed by intensive performance monitoring
  - Currently expanding to child and youth, co-morbid physical health problems, severe mental illness

Contrast with Canadian context

- Highly decentralized government structure
  - P/T jurisdiction over health and health insurance vs Australian federal Medicare
  - Federal government covers 23% total public spending on health in Canada vs 61% in Australia
- Deep but narrow approach to Medicare
  - First-dollar coverage but only of physician and hospital services
  - Inequity built in to two-tier system for non-physician providers
- Mix of grant- and insurance-based funding models
  - Community-mental health centres, collaborative care, although wait-times typically long
- Enhanced federal funding for some populations
  - First Nations and Inuit, veterans and military, federal corrections, refugees
  - Still subject to criticism re: availability, cultural safety, fragmentation
- 2/3 population with employment-based benefits
  - Compared to 1 in 5 with direct private insurance in Australia (1 in 10 in UK)

Mapping lessons learned

Planning	Funding	Service provision
Equity and scope	Monitoring	Sustainability

Mapping planning lessons

Use all policy levers	•IAPT grant-based model aligned with centralized control in UK, Better Access insurance-based model aligned with federal jurisdiction over Medicare in Australia. •Canadian provincial and territorial governments have jurisdiction for both grants and public health insurance, with less tax room but some relief from federal $5B transfer.
Increase supply	•IAPT built a dedicated workforce from scratch, Better Access drew on growing capacity in allied mental health workforce. •A plan to build workforce capacity (including baseline data) urgently needed in Canada, lest new public funding simply shift providers from existing programs without increasing access overall.
Engage providers and users	•Both IAPT and Better Access built support with the full range of providers (inc. GPs) through engagement, champions and incentives. •Support in principle strong in Canada (e.g. through CAMIMH, collaborative care) and on-going engagement needed on specifics. •Canada has an opportunity to be a leader in engaging service users and building in access to peer support.
Plan upfront	•IAPT built up step by step with continuous quality improvement, quick implementation of Better Access contributed to cost-overruns and weaker quality assurance. •Canada has evidence for prevalence, unmet need, costing, and return on investment, demonstration projects and workforce planning make sense as next steps.

The Commonwealth government wanted something done and wanted something done quickly. There is the question of what levers they can pull. The levers of things like the ATAPS services were more complex, and involved taking on a whole lot of additional responsibility, you have to set up and plan and deliver some kind of a stepped care model and you have to triage and you have to run in effect 100 little different mental health care systems one for each division. In contrast to which, what you have to do to get the funding out through Medicare is you create some Medicare Benefit Schedule entitlements and you create a process which legitimizes people to use them and away they go, the rest of it is done by the private sector.

--Australian researcher[*]

[*]Bartram, M. (2017). Government Structure and Equity in Access to Psychotherapy. Dissertation: Carleton University.

Mapping funding lessons

First-dollar vs co-payment?

- In keeping with UK and Australian health systems, IAPT is free and Better Access allows providers to require co-payments.
- In Canada, first-dollar services would be consistent with publicly-funded services (both insurance- and grant-based), but co-payments could discourage cost-shifting from employment-based insurance .

Grant vs insurance?

- IAPT grant-based approach gives strong control over costs and treatment fidelity but requires significant resources for administration, Better Access simply expanded Medicare but has had to address problems with cost overruns and quality assurance.
- Canadian provincial and territorial governments can draw on these lessons to assess trade-offs and avoid foreseeable pitfalls.

Assess cost-shifting

- Better Access has lower-copayments than direct private insurance in Australia, and private claims in Australian not only dropped by half but were dwarfed by the steep uptake of new public insurance.
- Canadians are also likely to seek whichever program is cheapest, but the impact of this effect could look very different with employment-based insurance and other service differences; monitoring is warranted.

Mapping service provision lessons

Broad range of providers

- IAPT uses low-intensity, high-intensity and supervisory therapists with IAPT-approved training, and Better Access added professionally regulated psychologists, social workers and OTs to Medicare.
- Canadian provinces and territories can start with regulated allied mental health professions (psychologists, social workers, OTs, and some psychotherapists), and also draw on certifications in peer support, substance use counselling, and psycho-social rehabilitation.

GP and self-referral

- GP-referral and treatment plan requirements strengthen continuity of care and cost control under Better Access, while by allowing both self-referral and GP referral IAPT has strengthened outreach to under-represented groups.
- A mix of both is warranted in Canada, where both self-referral to community mental health services and GP-referral to insured services and collaborative care are already practiced, and where physician shortages are more problematic than in either the UK or Australia.

Stepped/seamless care

- IAPT has implemented strong stepped care *within* the program but stands a bit apart from the rest of the service system, and Australia is just starting to consider how to build a stepped care approach to mental health (from Better Access, some online services, state services, primary care, etc.)
- Forging a stepped care model out in Canada's fragmented provincial and territorial mental health systems will require strong change management.
- Seamless integration with federally-funded services (for First Nations, Inuit, Metis, veterans, military personnel, refugees and people in the criminal justice system) requires additional attention in the Canadian context.

I think that it is often not realized that just announcing a policy and setting out targets and some money is not a very good way of getting things to happen. If you are rolling out something that is genuinely innovative and not just fine-tuning something that exists, we really need to put the support in place at a local level… This isn't about telling people what to do, it's about facilitating learning across different parts of the NHS and across different agencies.

--UK policy-maker[*]

[*]Bartram, M. (2017). Government Structure and Equity in Access to Psychotherapy. Dissertation: Carleton University.

Mapping service provision lessons, continued

Support implementation

- While Better Access implementation support has been limited to some initial training and communications, direct implementation support has been a key success factor for IAPT.
- Canadian implementation resources include CFHI, MHCC, CCSA, CADTH, Accreditation Canada, provincial health quality councils, specialized hospitals, and various research granting agencies (public and philanthropic).

Range of therapies

- IAPT covers CBT but also over a dozen NICE-approved therapies, and Better Access largely relies on professional self-regulation for quality assurance.
- Canadian reforms should at a minimum start with the full range of therapies approved by IAPT rather than just CBT.

Flexible caps

- In order to manage cost overruns, Better Access reduced caps from 6+12 to 6+4 (subject to GP review) and IAPT allows flexibility according to the evidence for different approaches; the *average* number of sessions is 5-6, but the range varies considerably.
- Some kind of flexible cap with a built in review process is warranted in Canada, with consideration of alignment to employment-based benefits.

There is this recognition that Medicare is going to give you the broad coverage, but if you want to really try to address specific levels of needs that might not be catered for well by Medicare, then you might need parallel programs that are specifically designed to try to address things.

--Australian researcher[*]

[*]Bartram, M. (2017). Government Structure and Equity in Access to Psychotherapy. Dissertation: Carleton University.

Mapping equity and scope lessons

Set equity targets

- IAPT equity outcomes have been uneven (by district, disadvantage, ethnicity, men, seniors) and utilization of Better Access has been much lower in rural and more disadvantaged areas; both universal services have been complemented by more targeted programs.
- Canadian programs should set and monitor explicit equity targets from the outset, and track the impact of universal and/or targeted services.

Mild to moderate scope

- Both IAPT and Better Access demonstrated results with an initial focus on mild to moderate depression and anxiety, and were then in a strong position to respond to pressures to expand to more severe problems, across the lifespan, etc.
- Canada could similarly start with a clear focus on mild to moderate mental health problems (and substance use, see below), with an explicit intention to expand in a second phase.

Include substance use

- While neither IAPT nor Better Access emphasize psychotherapy for substance use, neither excludes people with substance use problems.
- Canadian provinces and territories could break new ground (and align with efforts to improve the integration of mental health and substance use services) by explicitly including people with mild to moderate substance problems as eligible recipients for publicly-funded psychotherapy,

You could if you're not careful find yourself as a clinician working in a service where you feel … the outcome data is like a sword of Damocles hanging over you all the time…What you need to do is create a situation where you put in charge of these services really inspirational clinical leaders who are interested in the data, not because it's meeting targets and things, but instead because it's telling them and the service something really interesting about how they can achieve what they want to achieve with patients.

--UK researcher[*]

[*]Bartram, M. (2017). Government Structure and Equity in Access to Psychotherapy. Dissertation: Carleton University.

Mapping monitoring and sustainability lessons

Data, targets and leadership

- IAPT has demonstrated success against clear targets (backed by session-by-session data collection and monthly performance reports), but has to rely on inspiring clinical leadership to prevent risk of gaming and workplace stress; Better Access has demonstrated results but only through a one-off evaluation.
- Federal, provincial and territorial governments have committed to develop high-level indicators; with more political will, investment in data and clinical leadership, IAPT-style targets could be met or exceeded.

Clinical supervision

- Better Access relies on supervision requirements governing the practice of eligible allied mental health professions, and IAPT requires supervisors to have IAPT-approved training.
- Depending on the service system approach, Canadian reforms should build in explicit supervisory requirements from the outset.

Cultivate champions

- Clinical and bi-partisan political champions have been critical for first securing and then sustaining support for both IAPT and Better Access.
- Political and clinical champion for improved access to psychotherapy may be even more important in Canada, where federal/provincial/territorial dynamics provide a particularly challenging context for reform.

KEY MESSAGES

Access and equity can be improved

- The significant increases in access to psychotherapy that have been achieved in the UK and in Australia can be replicated in Canada
- The experience with IAPT in the UK and with Better Access in Australia provide important lessons for governments wishing to address the issue of limited and unequal access to psychotherapy services

Trade-offs: grant vs insurance-based

- IAPT's central control, tight management to standards and targets, and robust data have achieved impressive results
  - but require significant workforce and administrative resources
- Better Access' more hands-off reliance on professional self-regulation and administrative Medicare data has been able to greatly increase access
  - but provides less quality assurance
- Either IAPT's grant-based model or Better Access' insurance-based model would be feasible in Canada's more decentralized context
  - PTs have both sets of policy levers as well as targeted fiscal support from the $5B federal transfer

Adapting to the Canadian context

- Canada's deep but narrow Medicare model creates unique considerations regarding:
  - first-dollar coverage and co-payments, inequities in access to non-physician psychotherapy providers, potential cost-shifting from employment-based insurance, and stepped care
- While existing Canadian services are challenged by fragmentation, gaps and inequities, there are strengths to draw on in:
  - community mental health, collaborative care, employment-based insurance, and on-the-ground support for implementation
- Seamless integration with federally-funded services requires additional attention in the Canadian context, as does cultural safety:
  - First Nations, Inuit, veterans, military, refugees, federal corrections
- In Canada's decentralized and two-tier system, reforms will need a strong approach to performance management:
  - clear equity targets are particularly needed from the outset
- Workforce engagement, capacity development and increased supply have been key drivers for reform in both the UK and Australia:
  - may be even more so in Canada where mental health workforce planning (and data) is relatively weak.

Design and leadership

- Based on international lessons learned, either grant-based or insurance-based Canadian reforms should:
  - include a range of qualified providers and evidence-based psychotherapies
  - allow flexibility with referral mechanisms and session # caps
  - start with mild to moderate mental health problems before broadening the scope

- Canada has the opportunity for international leadership in:
  - explicitly including psychotherapy for substance use
  - engaging people with lived experience in the design and delivery of psychotherapy reform (including peer support)