



Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

Roundtable: Advancing Best Practices in e-Mental Health in Canada

Summary report

The Mental Health Commission of Canada

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*Mental Health Commission of Canada Roundtable
Advancing Best Practices in e-Mental Health in Canada*

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Mental Health Commission of Canada

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EXECUTIVE SUMMARY

E-health technologies have the potential to reach more people with high-quality care and improve outcomes. Yet they are not as widespread as they might be, especially in mental health care. To explore the reasons why and identify ways to advance e-Mental health, the Mental Health Commission of Canada (MHCC) hosted a roundtable meeting in Ottawa on December 1, 2016. Seeing e-Mental health as a catalyst for positive system change, the MHCC included it in two strategic directions of the Mental Health Strategy for Canada aimed at improving access to services and quality of care.

At the roundtable, health care leaders and frontline mental health practitioners from hospitals, community settings, regional health authorities and national associations across the country came together to discuss e-Mental health, with the goals of:

- Increasing awareness of the latest evidence that exists on the effectiveness/efficacy of e-health solutions in improving access to mental health care.
- Identifying and examining existing models of e-Mental health that have been implemented in health systems.
- Exploring recommendations to support the development, implementation and evaluation of current and/or future opportunities in e-Mental health.

The morning session began with a keynote address by Dr. Ed Brown, CEO of the Ontario Telemedicine Network. He shared thoughts on the challenge of scaling up effective e-health solutions from projects to the population level, and pointed to models for spreading technology throughout the health care system.

The question of scalability was one of several tackled by the morning panel of presenters. Fraser Ratchford of Canada Health Infoway shared insights into what Canadians want of e-health services; John Dick described the experience of Ontario Shores Centre for Mental Health Sciences in rolling out e-Mental health solutions; and Dr. Patricia Lingley-Pottie explained how the Strongest Families Institute has developed and scaled up both its distance care services and the information systems that support them.

Following a lunch and networking break, MHCC President and CEO Louise Bradley spoke about the importance of investing in e-Mental health to solve Canada's access-to-care challenges. While there is still a lot to learn about e-Mental health, the concept has strong potential that deserves exploration.

The second panel of the day described some of those explorations first-hand. Dr. Simon Hatcher of The Royal Ottawa Mental Health Centre spoke about his experience with e-Mental health solutions and the importance of sustainable implementation plans. Dr. David Gratzer and Faiza Khalid-Khan talked about the Scarborough Hospital’s Internet-Assisted Cognitive Behavioural Therapy (iCBT) solution—what it does, and lessons learned from implementation. Dr. Shalini Lal described the recently launched PRISM project, how it will give youth more direct pathways to care, and why post-project sustainability is the biggest challenge to be solved.

The last session of the day was a facilitated dialogue. Participants formed groups to discuss three related questions about barriers to—and facilitators of—e-Mental health, key priorities and who needs to be involved in implementation. Barriers ranged from privacy to funding to clinician buy-in, while the recovery model, individualized treatment and co-design with patients and communities were identified as facilitators. Virtually every conceivable stakeholder was found to have some role in the implementation of e-Mental health, suggesting it is truly a collective effort.

After the dialogue, participants had time to record what they felt were outstanding, unanswered questions about moving e-Mental health forward that might inform upcoming roundtables. Responses included how to determine which solutions work, devising a new funding model, increasing government and clinician buy-in, and reaching people with low socioeconomic status and other at-risk populations.

The meeting concluded with the MHCC reiterating that this was the first in a series of three e-Mental health roundtables to inform the organization’s advancement of e-Mental health in Canada.

KEY TAKEAWAYS

The following emerged from the roundtable as clear principles for future action on e-Mental health:

- **Investing in e-Mental health is essential** as it represents a way of addressing some of the Canadian health care system's biggest issues, including long waits to see mental health practitioners.
- **Clinicians must be onboard** as designers, champions and users of e-Mental health solutions.
- **A new funding model is needed** to support e-Mental health. Current models are not set up to pay clinicians to offer remote treatment for patients at home and post-discharge support.
- **The technology is out there.** The challenge is determining which solutions work and then scaling them across the health care system.
- **Scalability is key.** Planning must include a roadmap for taking a project from the pilot stage to full-blown implementation.
- **Sustainability is hard, but essential.** Getting started with e-Mental health innovations is often easier than sustaining them over the long term, yet that sustainability is vital to their success.
- **Privacy and security concerns must be addressed** for system-wide e-Mental health to be viable.
- **Standards and best practices must be developed** so solutions can be assessed, practices chosen and outcomes measured.
- **We need to think about vulnerable populations.** People living in poverty, for instance, may not be reachable by e-Mental health.
- **Everyone needs to be involved to resolve barriers to e-Mental health** — clinicians, not-for-profit organizations, medical schools, regulatory bodies, and federal and provincial/territorial governments all need to be engaged to push forward e-Mental health strategies.

INTRODUCTION

“**E-MENTAL HEALTH MEANS**...mental health services and information delivered or enhanced through the Internet and related technologies.”¹

(While there is no universal definition for e-mental health, the MHCC adopted the above quote from Christensen, Griffiths and Evans because it is broad enough to account for the constant evolution of technology.)

Champions of e-health extol technology’s potential to extend reach, increase access and improve the quality of care—whether by smartphone and social media platforms or robots and remote surgeries. While Canadians appear to have a growing appetite for these kinds of solutions as well, they are not as widespread as they might be, especially in the mental health arena.

The Mental Health Commission of Canada (MHCC) first brought together stakeholders to explore e-Mental health in 2012. Recognizing there was interest in better understanding the potential and implications of e-Mental health, the MHCC published *E-Mental Health in Canada: Transforming the Mental Health System Using Technology* in 2014. This briefing document looked at the e-Mental health picture in Canada, outlined how technology could transform the delivery of mental health services and discussed the barriers for implementation. It ended with nine recommendations to inform the development and spread of eMental health across the country.

With a renewed focus on e-Mental health, the MHCC is undertaking research and knowledge exchange activities to inform the development of a plan for driving e-Mental health. This includes hosting a series of roundtables to give key stakeholders and decision makers a forum for discussing e-Mental health in Canada.

The first of these roundtables was held in Ottawa in December 2016, bringing together healthcare leaders and frontline mental health practitioners from hospitals, community settings, regional health authorities and national associations across the country to discuss e-Mental health, with the goals of:

- Increasing awareness of the latest evidence that exists on the effectiveness/efficacy of e-health solutions in improving access to mental health care.
- Identifying and examining existing e-Mental health models that have been implemented in health systems.

¹ Christensen, H., Griffiths, K., & Evans, K. (2002). e-Mental Health in Australia: Implications of the Internet and Related Technologies for Policy. ISC Discussion Paper No 3, Commonwealth Department of Health and Ageing, Canberra.

- Exploring recommendations to support the development, implementation and evaluation of current and/or future opportunities in e-Mental health.

This report provides a summary of the day for attendees and other interested stakeholders who inform, design or deliver mental health services. Please note this report is a general reflection of the roundtable and is not intended to represent the perspective of any one individual or organization.

WELCOME AND OPENING REMARKS

PRESENTERS

Elder Paul Skanks

Band member, Mohawks of Kahnawake, Iroquois Confederacy

MaryAnn Notarianni

Manager, e-Mental Health, Mental Health Commission of Canada

After **Elder Paul Skanks** opened the session with a prayer for good intentions, roundtable moderator **MaryAnn Notarianni** set the stage for the day, explaining that the MHCC sees e-Mental health as key to its own strategies and as a catalyst for positive system change — drawing connections to the *Mental Health Strategy for Canada* and *Framework for Action*, the MHCC’s 2017–2022 strategic plan and several of the *Guidelines for Recovery-Oriented Practice*.

The MHCC is currently working to advance e-Mental health by focusing on three key areas: research, knowledge exchange and partnerships. This roundtable was the first of three scheduled as part of this year’s knowledge exchange activities.



KEYNOTE ADDRESS: Building a better, patient-centred health system with virtual care

PRESENTER

Elder Dr. Ed Brown

CEO, Ontario Telemedicine Network

Dr. Ed Brown observed we already have the technology to improve healthcare access and give patients tools to manage both their care and their conditions. The challenge is determining which solutions work best—and scaling them to population level to achieve a more accessible and patient-centred health care system. Dr. Brown outlined models for innovators to help technology spread across the healthcare system.

The Ontario Telemedicine Network (OTN) is doing its part through apps and services like eConsult, which has specialists electronically answer general practitioners' medical questions within days; OTNhub, a portal through which more than 25,000 healthcare practitioners offer telemedicine services; and the Virtual HealthCare Marketplace, which matches healthcare organizations with virtual healthcare solutions. In part through services like these, OTN facilitated nearly 328,000 mental health and addiction events in 2015/16, representing more than half the total events.

Dr. Brown noted that because e-health tools enable new and disruptive processes, it is essential to first understand what they can do, then imagine new processes and mindfully introduce those into the system. He cited two OTN programs. The first, OTN's Telehomecare program, is a chronic disease management model for people with heart failure or chronic obstructive pulmonary disease that has been supported successfully by remote monitoring and coaching. The second, a pilot that is currently being launched within the publicly funded system, is a system that gives patients access to same-day advice from a physician without going to the doctor's office. The challenge is identifying the best of these new models of care and how to scale them.

The question of scalability links to questions around access, which is often limited by specialist availability, geography and cost. Examples like the UK-based online mental health service, Big White Wall, demonstrate how access can be extended.

BIG WHITE WALL (UK/CANADA)

bigwhitewall.com

Patients waiting to see a healthcare provider can sign up to Big White Wall, connecting them to an anonymous online community of people going through the same thing. This can alleviate the sense of isolation that often accompanies mental health problems. Trained therapists lead discussion groups and monitor the community to ensure participants are safe. Big White Wall has been introduced to Ontario through an OTN pilot project.

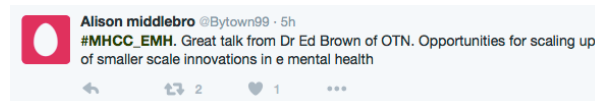
Where healthcare providers have been slow to adopt these types of solutions, the reasons can be many: lack of awareness, uncertainty about their credibility, reluctance to change and that current business models do not support them. Fairly, technology-enabled models of care have the potential to evolve the clinician’s role — from how they see patients and stay connected to them post-consultation to the use of “prescribing” apps and online tools, staying connected with patients after discharge and working in teams. Online social channels could even become a standard part of care.

PRACTICAL APPS (CANADA)

practicalapps.ca

With more than 165,000 health-related mobile apps available, it is difficult to determine which are effective and safe to recommend to patients. Practical Apps, a joint OTN and Women's College Hospital Institute for Health System Solutions and Virtual Care (WIHV) initiative, features mobile health app reviews by clinicians, which could include for apps aimed at alleviating mental health issues.

There are many questions to be answered around e-Mental health technologies. Dr. Brown left the audience with one in particular: “What are the challenges we can solve and the solutions we can scale *now*?”



Q&A HIGHLIGHTS

Are there barriers unique to Canada that account for its relatively slow rollout of telemedicine services?

From a global perspective, Dr. Brown said Canada is actually not far behind. Ontario is recognized as a world leader in traditional rural videoconferencing, although slower at adopting new models of care. A lot is being learned from the UK’s National Health Service and innovation in the U.S.

Should the public sector create new tools or leverage what the private sector has already created?

The public sector should be creating as little as possible, in Dr. Brown’s opinion. We need to leverage what is already out there. The challenge for government is picking winners while also enabling innovation through, for example, interoperability.

What is needed to advance an e-Mental health agenda for Canada?

A model to support it. The system also does not work from a financial perspective. For instance, a transitional care solution that cuts down hospital readmission rates will not save hospitals money because there will always be new patients to fill beds. Paying physicians for value and outcome rather than service would make a difference.

CONSUMER PREFERENCES & SYSTEM NEEDS: Insights and lessons learned to advance e-Mental health

PANELISTS

Fraser Ratchford

Group Program Director, Consumer Health and Innovation, Canada Health Infoway

John Dick

Chair of the Patient Council, Ontario Shores Centre for Mental Health Sciences

Dr. Patricia Lingley-Pottie

President and CEO, Strongest Families Institute

What do Canadians want when it comes to e-Mental health services? What do these services look like? And how can providers ensure pilot projects scale up to truly deliver farther reach and greater access to care? Those were some of the key questions addressed by the roundtable's morning panel of presenters.

PEOPLE-POWERED HEALTHCARE

According to Canada Health Infoway research, Canadians have some clear preferences and expectations when it comes to e-health. They want:

1. Access to personal information online
2. The ability to renew prescriptions online
3. The ability to book appointments online
4. The means to communicate with healthcare teams online

Canada Health Infoway's **Fraser Ratchford** gave a few examples of what these might look like in action, citing real projects from across the country: e-booking initiatives that let clients schedule appointments online, freeing staff to give extra attention to those who need it most; a "virtual visit" model tested in a BC study that increased patient satisfaction by eliminating the need for transportation and the cost of parking; and the Ontario Shores patient portal, which gives patients access to their personal health information and has helped reduce care provider medical record search times.

While some say Canadians are not ready for e-health, Canada Health Infoway has found 96% of citizens think it is important for the health care system to use digital tools, 86% say digital technologies make it easier to access information, and nearly all (96%) say health records should be kept electronically for easy sharing. Interestingly, 70% of those surveyed said they did

not currently have confidence that their healthcare providers were sharing information for a holistic view of their health.

While privacy and security are real considerations, Ratchford said among those surveyed, concerns about privacy and security were outweighed by desire for online information. Ultimately, the public's wish for digital solutions and greater control over their health (and health information) constitutes a shift even beyond today's notion of patient-centred care toward "people-powered healthcare", embodying the notion of "nothing about me without me" already familiar in mental health circles.

PUTTING THEORY INTO PRACTICE

John Dick talked about two e-Mental health projects at the Ontario Shores Centre for Mental Health Sciences. The first, Ontario Shores HealthCheck, is a secure, private and confidential Internet portal that helps patients manage their own health information using their own digital devices or those provided by their hospital.

Available to all patients 16 and older, HealthCheck lets users review reports, schedule appointments, track their visits, message their care teams, get explanations about medications, have prescriptions refilled and more. Family members and other decision makers can also have access with patient permission.

In Ontario Shores' second e-Mental health initiative, four units of patients have been given iPads and a mobile app to access personalized care. The application combines communications functions, hospital resources and individual learning tools so patients can stay connected to their care plans between appointments and access online support and information resources. The aim is to increase efficiency and provide an enhanced voice for patients within their own care.

The patients participating in the pilot represent a full cross-section of those dealing with mental health issues: transitional youth, individuals with eating disorders, patients receiving geriatric psychological services and others.

Dick concluded by asking that if, as the mental health field has been saying for years, every door should be the right door when it comes to access to care, is e-Mental health not the biggest door? It offers new ways to access services, extends the reach of care providers, and provides a private pathway to care that helps mitigate the impact of stigma.

A STUDY IN SCALABILITY

Dr. Patricia Lingley-Pottie closed the morning session with an overview of the Strongest Families Institute (SFI) and its innovative approach to service delivery. SFI's phone-based distance care service has a long track record of reducing wait times, side-stepping stigma and reaching geographically dispersed patients. With a grant from the Canadian Institutes of Health Research, SFI has built on its experience delivering distance care to develop IRIS: Intelligent Research & Intervention Software that streamlines and ensures efficient workflows and caseload management. Now at version 4.0, IRIS automates key tasks, enforces standard operating procedures, generates correspondence and alerts and helps SFI track patient progress and outcomes for greater accountability and quality of care.

Part of the goal of IRIS is to keep staff focused on highest-value activities rather than manual processes for routine administrative functions. For example, it can generate a two-page summary of the entire 17-week SFI intervention program for rapid customization to accelerate communication with families using the Institute's services. Dr. Pottie noted that as a result of implementing IRIS, the SFI can now respond rapidly and in detail to information requests from stakeholders such as the provincial governments—even if the specific report needed requires some customization.

The SFI uses the solution to ensure it is hitting its performance targets (e.g., callback times, length of intervention) and ensure that the coaches interacting with families are receiving acceptable scores from clients.

Dr. Pottie observed that scalability is key to any e-health/e-Mental health solution. Drawing on SFI's own experience growing an independent, not-for-profit lab at Nova Scotia's Centre for Research in Family Health from 700 clients and 16 staff to more than 3,000 and 42, Pottie identified a few essential factors for scaling successfully: understanding the landscape in which services are being offered, anticipating barriers, planning to address gaps and using customer satisfaction data to meet user needs. She noted that among the barriers are lack of funding and lack of awareness of which innovations work, and urged all participants to consider how innovative solutions can be scaled up.



Q&A HIGHLIGHTS

Would there be value in applying the SFI process to the Ontario Telemedicine Network?

Dr. Pottie said the SFI model would be applicable to OTN. The Institute—already offering services in Nova Scotia, Newfoundland, PEI, Alberta and parts of Ontario, and nationally for military families—has also received strong interest from New Zealand and Australia.

How can we engage people with lived experience and consumers in implementing these programs and approaches to make sure they are people-powered?

Panel members stressed the importance of engaging consumers from the outset, versus developing solutions and saying, “Here you go.” One example of how creativity can come from unexpected places when the right people are engaged took place at the Anishnawbe Health Centre in Toronto. There, counsellors are trained in Western psychotherapy and traditional Indigenous healing, and have come up with some unique online offerings.

What about techniques for underserved illness groups, not just underserved regions, to help local clinicians?

Panel members agreed on the need to look at specialized groups and ways to connect with patients directly. It was noted that the conceptual framework of the SFI can be applied to all kinds of conditions.

Are there any recommendations for MHCC supporting knowledge translation?

Early on when SFI first launched, MHCC was a major reason it gained traction across Canada — because it won an MHCC social innovation award. Having champions is key to raising awareness.

If we value digital technology in healthcare, how do we compensate physicians for the time and effort to integrate it into practice?

The panel agreed this was being put on the table more — that physicians have to be remunerated and be allowed the time to implement.

ADVANCING E-MENTAL HEALTH AND THE *MENTAL HEALTH STRATEGY FOR CANADA*

PRESENTER

Louise Bradley

President and CEO, Mental Health Commission of Canada

“If we don’t invest in this game-changing innovation, getting mental healthcare will remain a privilege. That simply should not be the case.”

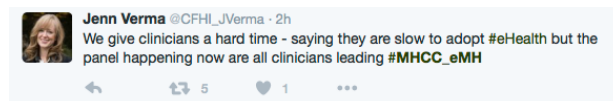
- Louise Bradley, President and CEO, Mental Health Commission of Canada

With mental health problems affecting one in five Canadians each year, raising awareness and reducing stigma are essential. Thanks to the MHCC and its peers, **Louise Bradley** said more and more people in Canada have been willing to seek help. Yet when doing so, many have encountered another barrier: lengthy wait times, sometimes over a year.

To address this challenge and raise awareness of the importance of investing in mental health, Bradley said the MHCC submitted an open letter to provincial and territorial ministers—co-signed by the CEOs of the Centre for Addiction and Mental Health and the Canadian Mental Health Association—urging that funds be set aside for mental health services. Canada is lagging behind other nations: of the billions spent on healthcare in Canada, only about 7% goes to mental health. The UK dedicates nearly double that, with 13% of National Health Service spending allocated to mental health.

Bradley said e-Mental health, which she called “the next big thing” in Canada, represents an opportunity to close the gap by improving treatment and access to early intervention. It is not just that technology is convenient and accessible: it is also often as effective as face-to-face therapies for mild to moderate mental health problems and illnesses, which frees up the system for more complex cases.

She ended by noting that while there is still a lot to learn, there are great opportunities to improve the lives of those who experience mental health problems and illnesses.



IN THE SPOTLIGHT: PROMISING PRACTICES IN E-MENTAL HEALTH

The afternoon panel drilled into ways mental health providers can leverage technology — citing both successes and a few cautionary tales.

PANELISTS

Dr. Simon Hatcher

Vice Chair Research, The Royal Ottawa

Dr. David Gratzer

Psychiatrist and Physician In Charge, Inpatient Mental Health Services, The Scarborough Hospital

Faiza Khalid-Khan

Patient Care Director, Mental Health Services, The Scarborough Hospital

Dr. Shalini Lal

Associate Researcher, Douglas Mental Health University Institute

E-THERAPY: STRATEGY VS. EXECUTION

Dr. Simon Hatcher advocated for realism in the approach to e-Mental health. He began by recalling a New Zealand project to automate cognitive function testing in a general hospital. While the technology developed had tremendous potential to save time and improve patient care, it was never implemented due to lack of budget, unclear governance, an undefined evolutionary path and practical impediments such as space concerns.

While technology is seductive, evidence of its effectiveness and cost-effectiveness is scarce. Recent systematic reviews, for example, have shown that telehealth is not economical and mostly helps patients with mild disorders who would have gotten better on their own. Further, people who may most need e-health technologies often have the least access to them, such as those in homeless shelters. In Ontario, one in seven homes are without Internet access, a figure that rises to 40% for households with annual incomes under \$30,000.

This does not mean technology has no use in mental healthcare. Hatcher is currently involved in an e-Mental health pilot involving middle-aged men who have recently attempted suicide. Participants can access face-to-face therapy via their smartphones, can program hotspots using GPS technologies to help avoid places that pose risks, and can call on help at the push of a button. The solution also includes a clinician dashboard for tracking how people are using the app.

Hatcher said there is reasonably good evidence that computerized therapies are as effective as human-led ones, but developing those therapies requires user involvement at all stages, including clinicians. Success hinges not only on the technology itself but also on budgeting

sufficiently, funding clinician time, and addressing issues of privacy, safety and managing high-risk situations. Solutions must also be future-proof, meaning not just scalable but also able to evolve over time instead of lapsing into obsolescence.

Hatcher ended with a recap: introducing technology is not straightforward; novel ways of delivering treatment need to be promoted (suggesting a possible role for MHCC); and the roles of the clinician in the process must be understood first and foremost.

IN PURSUIT OF SUSTAINABILITY

Dr. David Gratzer of the Scarborough Hospital talked about the institution’s iCBT solution—an Internet-based system for delivering cognitive behavioural therapy. He told the story of a patient, Ashley, whose struggles with anxiety and depression made it difficult to access services because she often found it hard to leave her house. iCBT allowed her to access care from home, and within six months of using it, she had moved into recovery.

Gratzer noted that iCBT is not just about an app or a site. It is a therapist-guided program delivered by social workers with multiple modes of delivery including phone and email, an online app library for CBT and mindfulness techniques and other reinforcements. He admitted the first version, iCBT 1.0, was not successful: 90% of people dropped out due to its “miss three sessions and you can no longer continue” rule. The hospital retooled the solution based on user feedback to make it more flexible and straightforward, and has found iCBT 2.0 effective with people of various needs, with a lower dropout rate than in-house treatment.

Given Canada’s vast size and population dispersion, and given its mix of cultures and languages, e-Mental health solutions like iCBT have the potential to bridge divides in ways an individual therapist cannot, delivering standardized care customized to people’s needs to increase effectiveness.

Dr. Gratzer’s colleague, **Faiza Khalid-Khan**, followed up with perspective on deploying iCBT from the hospital administration perspective. She acknowledged some of the barriers encountered: clinicians who still use pagers and faxes; a mega-hospital with 100 psychiatric beds that handles 500 outpatient referrals a month; a largely immigrant, low socio-economic client community, many members of which cannot miss work to attend therapy; and patients with typically moderate to severe symptoms.

“Ideas are easy. Implementation is hard. Sustaining is hardest.”

- Faiza Khalid-Khan, The Scarborough Hospital

Khalid-Khan noted that the hardest part was getting therapist buy-in. It took a while, but today, the hospital trains all new therapists in both classical and Internet-based CBT, and has a

partnership with the University of Toronto to train new practitioners in the tool—developing a talent pipeline. The Scarborough Hospital is now looking at iCBT 3.0, which is more of an e-therapy hub.

PROVIDING A MORE DIRECT CONNECTION TO CARE

PRISM—the Pathway for Rapid, Internet-based Self-Referral to Mental health services—is a four-year project out of the University of Montreal’s Hospital Research Centre to develop, implement and evaluate an integrated online self-referral pathway to help youth aged 11 to 25 quickly access mental health services.

Dr. Shalini Lal explained 75% of mental health issues first appear in adolescence and young adulthood, yet the same proportion—75%—of young people in need do not have direct and rapid access to appropriate care, and those in marginalized populations are even harder to reach.

At the same time, there is a disconnect between youth and the health system itself: youth prefer to seek help in their own ways while the system requires professional referrals. Options like Kids Help Phone have proven effective for crisis situations—though of interest, many young people would rather wait to use the live chat service Kids Help Phone has introduced than talk on the phone, sometimes holding online for up to 45 minutes for the chat option.

This is indicative of two things: one, that young people feel a lot of apprehension about seeking help; and two, that technology is intrinsic to how they are inclined to seek help. Dr. Lal referred to today’s youth as “technosapiens”.

PRISM is designed to help close the gap between a young person’s initial outreach for support and the transition to appropriate care, connecting users directly with mental health services. Its three-part online system includes an initial referral process; a referral management system that helps service providers manage and track referrals; and a secure communications platform that ensures confidentiality while allowing users to indicate how they want to be contacted.

The solution will be implemented at six Access Open Minds sites across Canada: In Quebec, Alberta, Ontario and Nova Scotia; in a mix of urban, semi-rural and rural settings. Dr. Lal said the project team anticipates the greatest challenges will be with post-project sustainability—how smaller sites will ensure continuity of the service, how to integrate with other data capture platforms and the like.

She noted that the current health system fragments people, and the way health technologies are being developed does the same. If we truly aspire to continuity of care, the ideal should be a single platform that everyone can access.

Q&A HIGHLIGHTS

How can organizations overcome healthcare providers' reluctance to adopt e-Mental health technologies?

Dr. Hatcher noted that learning new tools increased physicians' unpaid time in a system that pays them by the minute, creating a barrier to adoption. Dr. Gratzner said government support is, in a way, its own form of evidence—the proof is not just in papers published. Services need to be available. Faiza Khalid-Khan admitted staff left the Scarborough Hospital because working within the iCBT framework was not what they had signed on for; now they recruit people who are fully aligned with the approach.

Scalability and quality assurance are important: treatments become vogue and sometimes diluted because everyone thinks they can do them and there is no standard.

Khalid-Khan said mild cases are well suited to coaching and peer support but moderate and severe cases require psychologists and psychiatrists. iCBT includes weekly peer supervision for practitioners. Dr. Hatcher said an advantage of computers is that they deliver therapy consistently. But coaches are needed to guide people through the program. The QA and standard are in the computer, which essentially functions as the coaches' coach. Dr. Hatcher suggested a Canadian solution might be to get provincial or national online computer therapies for disorders and manuals for coaches.

For the pilot project involving middle-aged men who have attempted suicide, how are you resolving the tension between the data you are producing and privacy?

Dr. Hatcher explained participants do not have to use their real names, and the information stored complies with privacy regulations (what little there is).

FROM IDEAS TO IMPLEMENTATION

The last session of the day was a facilitated dialogue focused on three questions:

1. What are the barriers/challenges and facilitators for implementing e-Mental health?
2. Of the identified barriers/challenges, what are the top three priorities to address?
3. Who needs to be involved to support/facilitate the implementation of e-Mental health?

Participants divided into six groups and reported back their tables' answers to each question. Below is a digest of the responses fed back by each table as part of the group takeup. In general, participants seemed to agree with—and often echo—each other's thinking, suggesting some clear consensus on the barriers, enablers and key people to involve in implementing e-Mental health.

QUESTION 1

What are the barriers/challenges and facilitators for implementing e-Mental health?

BARRIERS	FACILITATORS
<ul style="list-style-type: none"> • Low socioeconomic status • Governance (determining who will lead, e.g., hospital, community) • Need for new funding model to make e-Mental health services viable and cover physician time to learn new tools • Resistance to change; lack of clinician buy-in • Safety fears • Privacy and security concerns • Many options; no standards for measurement • No accountability for health outcomes at population level—does not incentivize • Need for integration with other services • Defining ownership of health data (i.e., does it ultimately belong to the individual; are there standards that could be adopted to ensure shareability and measurement?) 	<ul style="list-style-type: none"> • Money • Recovery model (the needs/choice of people with lived experience and consumers is important) • Governance (good leadership, willing to invest) • Individualized treatment • Idea of co-design (with people with lived experience and consumers, community)

QUESTION 2

Of the identified barriers/challenges, what are the top three priorities to address?

While each table was invited to offer up three top barriers/challenges, the group collectively arrived at a longer list. The responses presented here are in the order they were reported, with duplicate suggestions omitted (although in several cases participants independently suggested the same priorities):

- Securing clinician buy-in
- Integration of services and platforms
- Developing overarching provincial strategies
- Changing the funding model, e.g., bundle payments, population-based funding, social financing
- Accountability in terms of addressing fears of potential risks
- Looking at outcomes and treatment adherence; we do not measure what we do or how well we do it currently, so do not know what to do in terms of implementing programs

QUESTION 3

Who needs to be involved to support/facilitate the implementation of e-Mental health?

This question yielded a wide and all-encompassing set of answers. As one table put it: “Who *does not* need to be involved should be the question.” One group did say it is sometimes difficult to know who should lead at what point in a project because technology solutions are often driven from an IT perspective, yet there are many other considerations to weigh.

The set of supporters required was listed out as:

- **People with lived experience and consumers** — Those with firsthand knowledge of the issues and mental healthcare services need to co-determine how e-Mental health should be integrated into Canada’s healthcare system.
- **Practitioners** — To tell patients or clients about e-services (some never do because they disapprove of the concept).
- **Experts** — The right people asking the right questions at every level, around the globe.

- **Partners** — Local partners and organizations like the MHCC and OTN to move from idea through innovation to local context and scale.
- **Privacy bodies** — To address privacy and other safety issues (e.g. Canadian Medical Protective Association).
- **Unions** — While often left out, unions are a “powerful force to be reckoned with,” especially when technology raises any fear of lost jobs.
- **Educational institutions and the bodies that regulate them** — These can be major levers in getting clinicians to change their practice.

WHAT QUESTIONS REMAIN?

Following the facilitated dialogue, participants were given time to answer the question, “What key questions remain or need to be resolved in order to move forward with e-Mental health?” to inform discussion for future roundtables. Common responses included how to:

- Determine which solutions should be scaled;
- Scale existing successful solutions;
- Avoid duplication of effort;
- Devise a funding model that supports everyone;
- Increase government and clinician buy-in;
- Disseminate evidence that e-Mental health works;
- Assess and resolve privacy and security concerns;
- Reach impoverished people and other at-risk/vulnerable populations; and
- Develop standards and best practices and, once developed, maintain them.

(See appendix E for the full set of responses.)

CONCLUSION AND NEXT STEPS

REMARKS

MaryAnn Notarianni

Manager, e-Mental Health, Mental Health Commission of Canada

MaryAnn Notarianni ended the meeting with reaffirmation of the MHCC's commitment to advancing e-Mental health by working with stakeholders and other organizations. She also asked that anyone interested in "staying on this journey with us" reach out to the MHCC.

Before thanking participants for attending and offering their views, Notarianni reiterated that the event was the first in the MHCC's latest series of e-Mental health roundtables and that a report for each roundtable would be made available in the future.

APPENDIX A: Meeting at a glance

Time	Item	Speaker
08:30 – 09:00	<i>Registration and breakfast</i>	
09:00 – 09:15	Opening	Elder Paul Skanks
09:15 – 09:30	Welcome and introductory remarks	MaryAnn Notarianni , Manager, e-Mental Health, Mental Health Commission of Canada
09:30 – 10:20	Keynote address and Q&A	Dr. Ed Brown , CEO, Ontario Telemedicine Network
10:20 – 10:40	<i>Health break</i>	
10:40 – 12:00	Consumer Preferences and System Needs: Insights and Lessons Learned to Advance eMental Health – Moderated Panel Discussion	Fraser Ratchford , Canada Health Infoway John Dick , Ontario Shores Centre for Mental Health Sciences Dr. Patricia Lingley-Pottie , Strongest Families Institute
12:00 – 12:45	<i>Lunch and networking</i>	
13:00 – 13:10	Advancing e-Mental Health and Advancing the Mental Health Strategy for Canada	Louise Bradley , President and CEO of the MHCC
13:10 – 14:20	In the Spotlight: Promising Practices in eMental Health – Moderated Panel Discussion	Dr. Simon Hatcher , The Royal Ottawa and University of Ottawa Dr. David Gratzer and Faiza Khalid-Khan , The Scarborough Hospital Dr. Shalini Lal , University of Montreal; University of Montreal's Hospital Research Center (CR-CHUM); and Douglas Mental Health University Institute
14:20 – 14:40	<i>Health break</i>	
14:40 – 15:45	From Ideas to Implementation – A Facilitated Dialogue	Facilitated by MHCC staff
15:45 – 16:00	Next steps and Closing	MaryAnn Notarianni , Manager, e-Mental Health, Mental Health Commission of Canada

APPENDIX B: List of participants

FIRST NAME	LAST NAME	TITLE	ORGANIZATION
Dr. Susan	Abbey	Psychiatrist-in-Chief, Centre for Mental Health	University Health Network
Aaron	Bond	Director, Specialized Services in the Northern Interior	Northern Health
Louise	Bradley	President and CEO	Mental Health Commission of Canada
Glenn	Brimacombe	CEO	Canadian Psychiatric Association
Dr. Edward	Brown	CEO	Ontario Telemedicine Network
Katherine	Chubbs	Vice President	Eastern Health
Lisa	Crawley	Past President/Co-Chair CAMIMH Committee	Canadian Federation of Mental Health Nurses
John	Dick	Chair of the Patient Council	Ontario Shores Centre For Mental Health Sciences
Jason	Evans	Policy Analyst	Public Health Agency of Canada
Dr. Ilan	Fischler	Physician-in-Chief	Ontario Shores Centre For Mental Health Sciences
Elizabeth	Fisk	Executive Director	Distress and Crisis Ontario
Teresa	Gerner	National Coordinator, Administrative and Government Relations	Canadian Mental Health Association - National
Dr. David	Gratzer	Psychiatrist	The Scarborough Hospital
Isa	GrosLouis	Director	Health Canada
Dr. Simon	Hatcher	Vice Chair Research	The Royal Mental Health - Care & Research
Sam	Hodder	Director Mental Health, Northern Zone	Nova Scotia Health Authority

FIRST NAME	LAST NAME	TITLE	ORGANIZATION
Katie	Hughes	Senior Director, Operations	Canadian Mental Health Association, BC
Alexia	Jaouich	Director, Implementation & Knowledge Exchange	Centre for Addiction and Mental Health
Dr. Nick	Kates	Chair, Psychiatry	McMaster University
Margaret	Kennedy	Vice President	Canadian Association of Social Workers
Faiza	KhalidKhan	Patient Care Manager	The Scarborough Hospital
Jennifer	Kitts	Director, Policy and Strategy	HealthCareCAN
Hannah	Kohler	Administrative Assistant	Mental Health Commission of Canada
Dr. Shalini	Lal	Associate Researcher	University of Montreal
Dr. Patricia	LingleyPottie	President and CEO	Strongest Families Institute
Andrea	Lucas	Director of Professional Practice	Waypoint Centre for Mental Health Care
Jane	Luhtasaari	Parliamentary Affairs Advisor	Officer of Senator Sinclair
Alison	Middlebro	Lead, Clinical informatics and EMR	The Royal Mental Health - Care & Research
Lawrence	Murphy	Counsellor	Canadian Counselling and Psychotherapy Association
MaryAnn	Notarianni	Manager, e-Mental Health	Mental Health Commission of Canada
Katherine	Parker	Special Advisor	Mental Health Commission of Canada
Lynn	Pelletier	Vice President	BC Mental Health & Substance Use Services - PHSA
Dr. Leora	Pinhas	Child and Adolescent Psychiatrist	National Initiative for Eating Disorders
Fraser	Ratchford	Group Program Director, Consumer Health and Innovation	Canada Health Infoway

FIRST NAME	LAST NAME	TITLE	ORGANIZATION
Megan	Schellenberg	Program Manager, e-Mental Health	Mental Health Commission of Canada
Lynette	Schick	Research and Policy Analyst	Mental Health Commission of Canada
Paul	Skanks	Elder	Mohawk Nation
Jeannette	Smith	Liaison Officer, Federal Programs, Nunavut, and Aboriginal Peoples	Canadian Agency for Drugs and Technologies in Health
Chris	Summerville	Chief Executive Officer/Co-chair CAMIMH	Schizophrenia Society of Canada
Marg	Synyshyn	Director for Child and Adolescent Mental Health	Winnipeg Regional Health Authority
Dr. Robyn	Tamblyn	Scientific Director	McGill University
Phil	Upshall	National Executive Director	Mood Disorders Society of Canada
Jennifer	Verma	Senior Director	Canadian Foundation for Healthcare Improvement
Melissa	Webb	Manager, Applications	The Royal Mental Health - Care & Research
Scott	Wolfe	Executive Director	Canadian Association of Community Health Centres
Carlos	Yu	Family Physician	College of Family Physicians of Canada

APPENDIX C: Presenter bios

HOST AND SPEAKER

Louise Bradley

A proud Newfoundlander, Louise started her career as a registered nurse in Corner Brook, Newfoundland, where she discovered an immediate passion for mental health.

Louise's work has taken her across the country, where she has held a range of positions across the health sector. From front-line nursing, to forensic and corrections care, to research, teaching, and large-scale hospital administration, Louise has seen mental health issues on the ground and at the highest administrative level.

Louise became President and CEO of the Mental Health Commission of Canada in 2010, after serving as Senior Operating Officer for the University of Alberta Hospital, one of Canada's leading clinical, research and teaching hospitals.

She holds degrees from Dalhousie University and Northeastern University in Boston, where she received a Master of Science with a specialization in mental health. She also received a Psychiatric Nursing Diploma with clinical practicum at Memorial University of Newfoundland's Harlow campus in Essex, England.

In June 2015, the Canadian College of Health Leaders presented her with the [Innovation Award for Health Care Leadership](#) for her work with the MHCC in encouraging future mental health pioneers. She was also given the Queen's Diamond Jubilee Medal in 2012 for her outstanding contributions to Canadian mental health.

In her years of work, Louise has heard from hundreds of people living with mental health problems and illnesses. Their stories are her inspiration to spark leading and lasting change for mental health care in Canada.

KEYNOTE SPEAKER

Dr. Edward Brown

Dr. Brown is a founder and Chief Executive Officer of the Ontario Telemedicine Network (OTN), one of the largest and most active telemedicine networks in the world.

A pioneer in the field of telemedicine, Dr. Brown has been recognized nationally and internationally for his contribution to the field. He has received numerous awards for his work, including being chosen as one of 25 Transformational Canadians by a national media panel sponsored by the Globe and Mail, CTV and La Presse in 2011. Most recently, he was awarded a Meritorious Service Medal by the Governor General of Canada in 2016 for his contribution to health care. He currently sits on the board of OntarioMD and is a past President and Fellow of the American Telemedicine Association.

An emergency physician who studied mathematics and engineering before embarking on his medical career, Dr. Brown is a passionate advocate for telemedicine as a tool to improve access to care, quality of care, patient experience and the sustainability of health care systems.

PANELISTS

Fraser Ratchford

Fraser Ratchford has a passion for making a difference and focuses on improving the experiences of patients/consumers and clinicians alike. Fraser is the Group Program Director for Consumer Health and Innovation at Canada Health Infoway, where he works with Infoway's partners to empower patients by providing them with secure, digital access to their health information and other consumer health tools.

Prior to his role at Infoway, Fraser held a number of leadership positions in health care. His major focus over the past 25 years has been digital health, working in government and hospital sectors, as well as in public health.

Fraser holds a MHSc, Health Administration from the University of Toronto, and a BMath Hons Co-op, Computer Science, Information Systems Option from the University of Waterloo. He is a Certified Health Executive with the Canadian College of Health Leaders.

John Dick

John Dick is the Coordinator of the Patient Council at Ontario Shores Centre for Mental Health Sciences (Ontario Shores), which provides a consumer's perspective on systemic issues and of services offered at Ontario Shores. Mr. Dick is one of the founding members of the Patient Council that was established at the center in 1993. He has been employed at the hospital for the past 10 years.

Mr. Dick who is a former consumer of the mental health system and has been a public speaker for the past 15 years with the (TAMI) Talking about Mental Illness which has spoken to over 50,000 high school and public school students about the Stigma of Mental Illness and addictions as well as professional workshops and adults. He has been featured in a Documentary about Stigma of mental illness entitled Extraordinary People. John is the recipient of the Attorney Generals Victims Services Award of Distinction presented to him in November 2008 at Queens Park. He is a recipient of the 2012 National Mental Health Award for Partnership from the Mental Health of Canada.

Dr. Patricia Lingley-Pottie

Dr. Patricia Lingley-Pottie is co-founder, President and CEO of the Strongest Families Institute in Halifax, Nova Scotia, Canada. She obtained her PhD. at Dalhousie University where she is Assistant Professor in the Department of Psychiatry and a Scientist at the IWK Health Centre (both in Halifax, Nova Scotia, Canada). Patricia has 27 years of pediatric nursing experience with expertise in research methods, scale development and the conduct of randomized clinical trials.

The past 15 years have been focused on psychological research, specifically harnessing the advantages of technology to deliver accessible and timely distance evidence-based interventions to children and families. Her research interests are in distance delivery systems, health outcomes, distance therapeutic alliance, the distance treatment experience and barriers to care. Patricia has published 23 articles and editorials. She is the co-recipient of the Canadian 2013 Ernest C. Manning Foundation Principal Award for Social Innovation. Strongest Families Institute received the 2012 Mental Health Commission of Canada Award for Social Innovation.

Dr. Simon Hatcher

Simon Hatcher is currently a Full Professor of Psychiatry at The University of Ottawa. He moved there from Auckland in May 2012. He trained in psychiatry in the UK and then worked for 18 years in Auckland, New Zealand as a clinical academic running a Liaison Psychiatry in a general hospital and at The Department of Psychological Medicine at The University of Auckland.

His main research interests include suicide, self-harm, psychotherapies, psychiatry in the general hospital setting and e-therapies. He has been the principal investigator in several large trials of non-pharmacological interventions in people who present to hospital with intentional self-harm. He provided the clinical input into the John Kirwan Journal program www.depression.org.nz. Currently he works in the downtown homeless shelters in Ottawa and the Liaison Psychiatry service at The Ottawa General Hospital. He is the vice chair of research in the Department of Psychiatry.

Outside work he enjoys motorbiking, flying, hiking, kayaking, creative writing and restoring bush to its native state.

Dr. David Gratzer

Dr. David Gratzer is a physician and a psychiatrist. He is the physician-in-charge of inpatient services at The Scarborough Hospital, and co-leads the e-therapy initiative. Dr. Gratzner is a lecturer with the University of Toronto and serves on the editorial board of The Canadian Journal of Psychiatry. His articles, papers and book chapters on psychiatry and technology have been published widely, including CMAJ (his review paper on iCBT—the first such paper in Canada—was featured on the front cover of the March 1 issue).

Faiza Khalid-Khan

Faiza Khalid-Khan completed her B.A. Honours in Psychology and English Literature from York University and her M.S.W. from the University of Toronto. She has worked at The Scarborough Hospital (TSH) for over 15 years in various clinical positions as a Social Worker in the Mental Health Department, including serving on the crisis team in the ED as well as on the mental health inpatient units. In 2012, she took on a management position where she has led the team to build a new program based on evidence-based practice. Currently she is the Patient Care Director of Mental Health Services at TSH. Her interests include using technology to provide patient-centered care, especially the development and implementation of e-therapies. She is currently leading a project to develop brief, focused e-therapies for the Community Crisis Program at TSH.

Dr. Shalini Lal

Assistant Professor in the School of Rehabilitation, Faculty of Medicine, at the University of Montreal; Principal Scientist at the University of Montreal's Hospital Research Centre (CRCHUM); Associate Researcher at the Douglas Mental Health University Institute; and Director of the Youth Mental Health and Technology Lab.

She worked for 10 years as a clinical service provider and clinical leader with young people and family members within the mental health care system in different roles including community-based case manager, occupational therapist, and clinical program coordinator, prior to pursuing her PhD.

Dr. Lal's research program, supported by a 5-year New Investigator Salary Award from the Canadian Institutes of Health Research, is focused on investigating the use of technology to improve access and quality of mental health services provided to youth. She has also previously conducted research on the impact of services on youth resilience, recovery, and service engagement, based on patient and family perspectives. She is interested in new technologies, peer, and arts-based approaches to conduct research to improve service delivery and uses mixed methods, qualitative and participatory approaches in her research.

Dr. Lal is involved in research projects with collaborations in Canada, India, and Australia; she is one of the Principal Lead Investigators of ACCESS Open Minds, a pan-Canadian network that is implementing and evaluating service transformation in youth mental health in several sites across Canada; and is the Principal Lead of the PRISM (Pathway to Rapid, Internet-based Self-referral to Mental health services for youth) project, funded by the Canadian Institutes of Health Research and the Graham Boeckh Foundation.

Appendix D: e-Mental health resources

The e-Mental health programs, practices and resources listed below were provided by participants who filled out the pre-meeting survey.

ORGANIZATION	RESOURCE	LINK
	Interactive Computer-Assisted Client Assessment Survey (iCCAS) Ferrari, M., Ahmad, F., Shakya, Y., Ledwos, C., & McKenzie, K. (2016). Computer-assisted client assessment survey for mental health: patient and health provider perspectives. <i>BMC Health Services Research</i> , 16, 516.	ncbi.nlm.nih.gov/pmc/articles/PMC5035495
Canadian Agency for Drugs and Technologies in Health (CADTH)	Telehealth: Summary of evidence tool (includes a section on telehealth for mental health)	cadth.ca/telehealth-summary-evidence
CADTH	Telehealth Assessment of Patients Being Retained for Emergent Mental Health Reasons: Clinical-Effectiveness and Guidelines	cadth.ca/telehealth-assessment-patients-being-retained-emergent-mental-health-reasons-clinical-0
CADTH	Telehealth Services for the Treatment of Psychiatric Conditions: Clinical Effectiveness, Safety, and Guidelines	cadth.ca/telehealth-services-treatment-psychiatric-conditions-clinical-effectiveness-safety-and-guidelines
Canadian Mental Health Association — British Columbia	Bounce Back Online website	bouncebackonline.ca
Klinik Community Health Centre, Canadian Association for Suicide Prevention and the Winnipeg Suicide Prevention Network	Calm in the storm mobile app	calminthestormapp.com
McMaster University	Electronic psychotherapy training program	pter.mcmaster.ca

ORGANIZATION	RESOURCE	LINK
Ontario Shores Centre for Mental Health Sciences	Portal that allows patients to view their reports, labs, appointments, securely message their providers and request prescription renewals	ontarioshores.ca
Ontario Shores Centre for Mental Health Sciences	In the process of implementing: <ul style="list-style-type: none"> • Virtual traumatic stress clinic using an evidence-based app with clinician OTN support • Patient-engagement app that lets patients document, complete scales and therapy homework, receive reminders for medications & therapeutic activities and have information that patients enter sync back into the hospital's EMR 	ontarioshores.ca
Palouse Mindfulness	Online mindfulness-based stress reduction	palousemindfulness.com
The Royal	OSI Connect mobile app	theroyal.ca/mental-health-centre/apps/osi-connect
The Royal	HealthyMinds mobile app	theroyal.ca/mental-health-centre/apps/healthymindsapp
The Royal	Active telemedicine practice throughout the organization	theroyal.ca
Worldwide Therapy Online Inc.	Therapy Online website	therapyonline.ca

APPENDIX E: Key questions

Following the “From ideas to implementation” facilitated dialogue, participants were allotted time to write down what they felt were key questions that need to be resolved to advance e-Mental health in Canada. The full set of responses is below, transcribed from participants’ handwritten notes. There may be errors or omissions due to penmanship and/or interpretation by the transcriber.

What key questions remain or need to be resolved in order to move forward with e-Mental health?

- How do we scale up existing successful programs?
- Funding models for all service providers—fee codes, etc. What will this process be/how will this pay out?
- How do we convince governments to “buy in”?
- How can we change the mentality of society — that e-Mental health works and should be incorporated/engrained in mental health practices?
- How do we convince docs to ‘buy in’?
- How are the federal and provincial governments going to work together to advance an e-Mental health strategy?
- How do we mobilize investments in e-Mental health when it means taking away from acute, inpatient services?
- How are we going to shift the privacy and confidentiality conversation? The patient owns his/her information, not the professional.
- Guidelines to move from an ‘idea’ to action/implementation?
- Where is addictions at in the conversation of e-Mental health? Collaborate efforts with CCSA. Role for National conversation with Accreditation Canada.
- How do we expand the reach to those who are most at risk/vulnerable?
- I would like to see a literature review produced regarding the evidence related to e-Mental health initiatives.
- A briefing on privacy for each province and territory would be helpful as well to ready ourselves for implementation.
- Opportunities for knowledge exchange so perhaps forums in each province and territory we can learn what is happening across the country.
- How can we support movement forward using tools that are evidence based and have clearly demonstrated positive outcomes, while preventing use of public fund on apps etc. of questionable value?

- Ensure clinical quality while introducing innovative tools, and while sustaining use.
- Equity issues: access for people living with poverty, which is disproportionately higher for people with severe and persistent mental illnesses.
- How best to encourage service providers to embrace this way of delivering service.
- Need to clarify/resolve issues of use of technology, e.g. confidentiality, security, in a transparent way so they do not continue to be barriers.
- How to disseminate information (KE) on the efficacy of e-Mental Health!
- How do we reduce the reluctance to adopt e-Mental health solutions?
- How do we effectively identify those evidence based practices that are ready to scale up in a way that is accepted by all the key players?
- How do we ensure sustainability of those best practices once implemented?
- Resolving provision of services across provincial and territorial boundaries.
- Dissemination of research and evidence of effectiveness.
- More of this! Tremendously valuable opportunity, much appreciated.
- How do we ensure e-Mental health is an enabler of: policy reform (where needed); best/promising practice documents and resource allocation.
- Is there an ability to have targeted funding for this, especially up front to support both practices and cultural change?
- How best to move forward with facilitation/interoperability/integration between Canadian based e-Health solutions. Is there funding incentives or mechanisms that can support this?
- What does a Canadian (and a provincial) based e-Mental health strategy consist of?
- How best to increase capacity of mental health providers to deliver e-Mental health services?
- We have a very outdated physician fee schedule. For psychiatrists, in the past, psychiatry and mental health treatment was focused on pharmacology. We have shifted now to non-pharmacological approaches, especially psychological interventions yet psychiatrists are not embracing these. These interventions such as CBT, DBT, and mindfulness lend themselves to a variety of formats and translate well to e-Mental health.
- National and provincial alignment in e-Mental health strategy.
- More integration between hospital, outpatient, community (by electronic medical records and bundled payments and other business models). We have great examples from UK and Australia, why are we not learning more from them?
- What will the role of the Federal Government vs. the provinces and territories?
- What will be the standards either provincially/territorially or Federal?

- Need to develop a strong evidence based business case before moving forward.
- Privacy — real or perceived, how to?
- Effectiveness — having different perspectives.
- Funding models: Government/Funders need to take a step back and look at our current models — in Ontario, it is not working for mental health.
- Shared/centralized systems: We need to leverage and use economics of scale with technology investment.
- Connectivity in rural areas (all across Canada): We need to pressure for free internet for all in order to enable this effort.
- We need to become more sophisticated in how we pursue partnership — if you are trying to get started vs. looking to scale — those require different types of expertise. Also, a single truth about innovation is that it often (always) happens with committed clinicians & PT's. Let's support them — give patients real responsibility; pay clinicians for innovative practice.
- Could a summary of what works (the OTN's app library idea) for all of Canada, but beyond apps to examples of integrity e-Health in health care = new model of care.
- Funding (ongoing) and need models. The need for change management tools to sustain change.
- An understanding that *one* solution is not the answer and e-Mental health can take many different forms.
- When there is no 'new money' how does innovation get funded? Going to the 'public/private' through means other underfunded sectors like arts/sports do not get the \$ they need.
- What are the minimal privacy and security standards for implementation of e-Health Initiatives?
- How can funding models be shifted to support population based/bundled care vs. current volume-based care.
- What are the best evidence-based e Health solutions that are easily scalable?
- What are the key e-Mental health tools that we should scale now?
- What is next?
- How do we get the support to ensure action?
- Whom to engage to get the ball rolling?
- The identification and validation of safe and effective e-Mental health services for specific populations?
- How to design a funding model or models that are acceptable to payers, service providers and patients.

- How does the professional side (service providers) work in hand with, work collaboratively with non-profit groups like SSC and MDSC so as to avoid duplication (i.e. e-CBT) and vice-versa?
- Where do non-profits get funding to implement e-Mental health as we struggle with lack of capacity, capability, competency in e-MH, and resources?
- Provide more examples of e-Mental health!
- How do we scale up to maintain quality?
- What needs addressing that is unspoken are turf wars and *? If two programs develop a similar e-MH intervention, who gets scaled up?
- How do we ensure the interventions are more than 'telling' PT's what to do?
- Privacy and clinical buy-in.
- Risk liability including unions, funders, and professional regulatory bodies.
- Ensuring no duplication occurs.
- How to appropriately measure outcomes?
- Patient record ownership defined in the Canada Health Act.
- Federal mandate of information standard tied to transfer payment.
- Involve international experts to build a system that is national.



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[in /Mental Health Commission of Canada](https://www.linkedin.com/company/mental-health-commission-of-canada)