Roundtable:
Exploring Policy Considerations for Expanding Access to Counselling, Psychotherapies and Psychological Services in Canada

Summary Report

Mental Health Commission of Canada
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Mental Health Commission of Canada Roundtable
Exploring Policy Considerations for Expanding Access to Counselling, Psychotherapies and Psychological Services in Canada

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Delta Hotels Ottawa City Centre
101 Lyon Street N
Ottawa, ON

Mental Health Commission of Canada

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Executive Summary

Ensuring Canadians have access to the right mental health services in the right place at the right time is essential to improving mental wellness in an equitable and effective way. The Mental Health Commission of Canada gathered policymakers, practitioners and other sector stakeholders for a daylong facilitated discussion of how best to expand access to such services and overcome current barriers to doing so. The goals of that session were to:

1. Increase understanding of diverse stakeholder perspectives
2. Identify key issues and considerations in the current policy landscape
3. Discuss preferred approaches to expanding access to counselling, psychotherapy and psychological services in Canada
4. Explore shared next steps

Setting the context

Howard Chodos, Ph.D. presented research into the pros and cons of two main public funding models for expanding access to counselling, psychotherapy and psychological services: insurance funding and grant funding. He suggested the criteria for choosing the right model for Canada should include: affordability, sustainability, ability to respond to priority needs, cost-effectiveness, the number of people who would gain access, political feasibility (either would require mobilizing multiple levels of government), as well as the ease and speed of implementation. He noted other questions that need to be resolved, including how to determine who should have access to public funds and whether to provide full coverage or charge a deductible, and suggested any model for increased access would present an opportunity to collect data and measure outcomes.

Avenues for expanding access

In table groups, participants then broke out to discuss some foundational questions about barriers to increasing access and how to overcome them. Those conversations took a largely "system view" and discussed macro philosophical positions, poor understanding of system capacity, data quality and territoriality among players. A number of projects currently underway were identified as addressing some of these barriers.

In thinking about avenues other than funding that could potentially increase access, participants generally agreed that reigning paradigms must be challenged and there must be a willingness to "take the paths not typically chosen".

Funding approaches

In considering the relative merits of insurance versus grant funding, participants cautioned against creating unintended consequences and noted challenges in either case of promoting equity, measuring outcomes, assuring quality and others. As to whether or not other options might be feasible, the groups

said to answer that question other questions would need to be answered first related to determining diagnoses and care pathways, system navigation and assessing capacity.

Additional policy considerations

From a policy perspective, participants once again took a largely macro view, identifying systemic changes that could enable meaningful improvements, including making the system smarter, building business cases or expanding on existing ones to justify decisions, establishing an integrated data strategy across all provinces and territories, and targeting mental health spending where it is needed most (though there was some discussion about how, exactly, to define what it means to be "needed most"). In the end, participants agreed the key is to get started — to try something to solve the access challenge.

Closing roundtable

Rounding out the day, participants shared their reflections on the session. Most felt the session was productive, inspiring and provided ample opportunity for making professional connections. Several also touched on directives for future action.

Key takeaways

The following emerged from the roundtable as possible principles for expanding access to counselling, psychotherapies and psychological services:

- **Focus on outcomes** — Decisions about changing the mental health system to increase access should begin with a clear sense of the desired outcomes and work back from those, providing a basis for measurement.
- **Funding may not be an either/or decision** — While discussions were framed by considering two potential mental health funding approaches — insurance funding and grant funding — the ultimate best answer may be a hybrid of the two, or involve other approaches as well.
- **Understand capacity** — To effectively choose a funding approach or structure for service delivery, it is essential to have a better grasp of human resource needs and capacity across the continuum of care. Understanding the system's capacity to deliver counselling, psychotherapy and psychological services is an important first step toward assessing the feasibility and sustainability of approaches to expanding access.
- **Test everything** — To avoid the risk of unintended consequences, new approaches should be piloted and evaluated.
- **Ensure equity** — Marginalized populations need to be better served by the system, and any changes should ensure this, accounting for jurisdictional differences as some provinces or territories may not currently have the same infrastructure to implement.
- **Fully engage people with lived experience and their families** —The system should be changed not for the sake of those who work within it but rather for those served by it. Involving people with lived experience and their families in system transformation will help ensure this.

- **Keep working together** — Sharing best practices and new evidence and collaborating to ensure consistency across jurisdictions are all key to achieving equitable access to counselling, psychotherapies and psychological services.
- **Start somewhere** — Debating approaches stimulates ideas and reveals possibilities, but to make change happen, real action needs to be taken.

"Other countries have expanded access in their own ways. The question for today is, how do we make it happen in Canada?"

~ Ed Mantler

Part 1: Setting the Context

Welcome and opening remarks

Ensuring that Canadians have access to the right mental health services in the right place at the right time — whether those are counselling, psychotherapy or other psychological services — is essential to improving mental wellness in an equitable and effective way.

The Mental Health Commission of Canada gathered policymakers, practitioners and other sector stakeholders for a daylong facilitated discussion of how best to expand access and overcome current barriers to doing so.

Ed Mantler set the context for the event, noting that numerous stakeholders have been working for many years to address barriers to access for counselling, psychotherapy, and psychological services. The Commission convened this roundtable to contribute to that work in the present climate of new funding for mental health, drawing together policymakers and stakeholders from across the country to advance the conversation and explore avenues for building on current initiatives.

Mantler acknowledged access to services is currently insufficient to support the one in five Canadians each year who will grapple with a mental health problem or illness. He noted that while the erosion of stigma is a welcome development, it has deepened the problem as more and more Canadians seek the help of qualified providers.

> **SPEAKERS**
>
> **Ed Mantler**
> Vice-President, Programs and Priorities, Mental Health Commission of Canada
>
> **Hugh MacPhie**
> Principal, MacPhie & Associates

Pointing to robust data on the effectiveness of evidence-based mental health services as well as evidence suggesting investments in improving access yields significant returns, Mantler concluded: "There's no question that expanding access is the right thing to do."

The roundtable facilitator then set out the objectives for the day:

1. To increase understanding of diverse stakeholder perspectives

2. To identify key issues and considerations in the current policy landscape

3. To discuss preferred approaches to expanding access to counselling, psychotherapy and psychological services in Canada

4. To explore shared next steps

He noted that the aim of the discussions would not be to reach explicit closure or consensus, but rather to share and understand different points of view, to generate collective thinking that participants could take away with them to advance their own work, and to explore possible shared next steps.

> *"If we treat people properly, in ways we know work, there's money to be saved down the road. But 'money down the road' is not always a strong motivator to get governments to invest upfront."*
>
> ~ Howard Chodos, Ph.D.

Overview of considerations

There are two possible approaches to using public funds for improving access to counselling, psychotherapy and psychological services in Canada, according to Howard Chodos. He shared his thinking with participants to set the foundation for the day's discussions.

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SPEAKER

Howard Chodos, Ph.D.
Consultant, Mental Health
Commission of Canada

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Looking at the evidence

Echoing Mantler's assertion of the necessity of improving access to services, Chodos led his presentation with a quote from Robert Salois, who was then the former health and welfare commissioner for Quebec:

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

But determining that "best approach" will not be easy, said Chodos. While there is strong evidence that counselling, psychotherapy, and psychological services work — and that patients often prefer those modalities to medication — Canada's health care system hinders access to them, in part because it only funds services that are deemed "medically necessary" under the *Canada Health Act*.

Limited publically-funded counselling, psychotherapies, and psychological services are available in most jurisdictions through hospitals and community health centres, but no jurisdiction provides adequate coverage to these services. Private insurance may grant access to those who have it, but insurance plans often do not offer enough coverage for the number of sessions research suggests would be effective.

Avenues for improving access

Noting that avenues for improving access to services are limited in the Canadian context, Chodos listed three possibilities and their related issues. The first, bolstering coverage through private group insurance plans, could have limited impact, at best covering the 60 percent of Canadians who have insurance through their employers. The second option, increasing the amount of counselling, psychotherapy and psychological services delivered by physicians, would require additional training for family physicians

(who would consequently have less time to perform other services) and shifting priorities for the already insufficient number of psychiatrists.

According to Chodos, the most promising option is the third: using public funding to pay for the services of the many providers not currently covered under Medicare. This would require more public funding and determining the best way to organize the system for the greatest impact.

To that end, Chodos presented two strategies for applying public resources:

1. **Insurance funding** — A public insurance plan that would effectively allow counselling, psychotherapy and psychological service providers to bill government for their services.

2. **Grant funding** — Public money allocated to hospitals, community health centers and other publicly funded health care and social service vehicles to pay providers of counselling, psychotherapy and psychological services.

Chodos noted that both models have merit and both are already in use as such across Canada and constitute the joint foundation for publicly funded health care in the country. For instance, fee-for-service physicians are paid through insurance and many hospitals are funded through block grants they are free to allocate. Each model has also been successful in expanding access to mental health services in other countries: Australia and Britain, for example, have used upfront government funding coupled with careful consideration of how insurance funding or grant funding respectively could be adapted to their countries' existing public health care and insurance systems.

Criteria for judging which model is more suitable for Canada include affordability, sustainability, ability to respond to priority needs, cost-effectiveness, the number of people who would gain access, political feasibility (either would require mobilizing multiple levels of government), as well as the ease and speed of implementation.

Chodos listed what he sees as the primary strengths and weaknesses of each model (see table 1 and table 2).

Table 1: Insurance funding

STRENGTHS	WEAKNESSES
• Could provide universal coverage; also possible to target specific populations • Could provide access to a wide range of providers • Builds on existing private insurance system • Providers practice in most communities • Could be a uniform pan-Canadian program • Could be administered by one or more levels of government	• Can be difficult for government to constrain costs • Will require changes to regulatory and certification regimes • Will likely require specific mechanisms to encourage the coordination and integration of services • Requires negotiations on fee rates between professional organizations and funders

STRENGTHS	WEAKNESSES
• Very difficult for the funder to cancel the program once it is up and running	• Will likely require regulation of private insurance and negotiations with private insurers to ensure complementarity

Table 2: Grant funding

STRENGTHS	WEAKNESSES
• Could be integrated with existing primary health care and community mental health care services • Can be used with a wide range of providers • Can be structured to provide stepped care • Can target specific populations • Allows flexible application in different jurisdictions • Costs can be constrained	• Could require training new categories of provider • Must function at close to capacity in order to provide value for money • Services can be scaled back by funders facing fiscal constraints • Requires a structured entity or practice to employ or contract with providers

Moving forward

Beyond the question of which public funding model is right for Canada, Chodos raised several other considerations he said need answers before a decision can be made — including how to determine who should have access to the public funds, as not all providers currently providing some forms of counselling and related services are regulated. He also questioned if first dollar coverage was desired or if patients would pay a deductible, as is currently the case in Quebec's pharmacare plan, and suggested implementing either model would present an opportunity to collect data and measure outcomes — but doing so would require agreement on what to measure.

Q&A highlights

Following Chodos' presentation, one participant cautioned against placing the notion of "evidence-based" above all else. There is a requirement for providers who can treat complex cases and deliver services according to individual need rather than limiting sessions to whatever number evidence suggests can be effective.

Another participant questioned what expanding insurance plan coverage for counselling, psychotherapies and psychological services would do to insurance rates. Chodos said he had not explored that consequence as part of his research, but bolstering private plan coverage did seem to be one possible avenue for improving access. He pointed to findings in the MHCC's *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, which revealed many Canadians had insufficient coverage through employment-based plans.

Part 2: Avenues for Expanding Access

Calling the first working session of the day a "generative discussion", the facilitator posed four foundational questions to participants in their table groups, aiming to elicit a wide range of views on barriers to access, current projects addressing those barriers, and compelling avenues for increasing access to counselling, psychotherapies and psychological services.

A focus on the system

Many tables cited the same or similar barriers to access when reporting back to the wider group, concentrating for the most part on those at the system level:

- Macro policy and philosophical barriers
- Understanding human resource needs and system capacity
- Gatekeeper bottlenecks
- System literacy
- Resource optimization
- Accountability
- Data quality
- Equity
- Territoriality
- Systemic stigma

> **GUIDING QUESTIONS**
>
> 1. **What barriers stand in the way of increasing access to counselling, psychotherapies and psychological services?**
>
> 2. **What relevant work is underway for addressing these barriers and expanding access?**

When asked to think about relevant work currently underway to address those barriers and expand access, participants offered the following:

- Data set gathering, e.g., Statistics Canada and McMaster University looking at children's utilization of mental health services

- Ontario data strategy to support system transformation

- Anti-stigma initiatives (MHCC, Bell *Let's Talk*, campus mental health)

- Children's mental health collaboration in Ottawa

- Ontario youth engagement strategy

- Stepped care models

- Integrated services for youth and emerging adult mental health

- Peer support accreditation

- Technology initiatives, tele-Mental health and e-Mental health

- Ontario child health survey (Big Data)

- Ontario comprehensive mental health and addictions strategy (across 14 ministries)
- Canadian Institutes of Health Research (CIHR) SPOR network (Strategy for Patient-Oriented Research)

- Pathways of care
- Strong advocacy, provincially and federally
- Federal transfer targeting for mental health
- General increase in collaboration, whole-of-government activities

Where ground can be gained

In thinking about avenues other than funding that could potentially increase access, participants generally agreed that reigning paradigms must be challenged and there must be willingness to "take the paths not typically chosen". Specific suggestions included:

- Decreasing downstream demand through prevention and promoting wellness
- Adopting person-centred approaches
- Strengthening mental health literacy
- Improving systems and pathways to care
- Breaking down silos through public–private partnerships
- Technology
- Innovation and flexibility

> **GUIDING QUESTIONS**
>
> 3. Other than funding, what avenues for increasing access should be explored?
>
> 4. What makes each of these avenues interesting, attractive, or worth exploring?

Discussion in depth

In talking through the first two questions, participants made the following points:

Macro policy and philosophical barriers

There is a "philosophical disconnect" between physical health and mental health approaches, with physical health receiving more funding. Mental health needs equal treatment, and policymakers and funders need to understand mental illness as a health problem. At the same time, a purely medical model for mental health services can be a barrier.

Understanding human resource needs and building on system capacity

With limited shared understanding of available skills and scopes of practice across professions, and even basic terms like "psychotherapy" subject to different definitions, we need better understanding of service capacity. Are there enough trained professionals to fulfil the "right provider, right time, right place" mantra? We should accept roles for people with different levels of training — peer support workers, college graduates, different types of therapists — as well as coaching (along the

lines of Strongest Families[1]). All of this also will enable better planning and matching of needs to competencies.

Gatekeeper bottlenecks

Primary care professionals are often the gatekeepers who refer patients on to services, but do not always know what is available. There should be more collaboration — a team approach — and other points of entry as in the stepped care model.

System literacy

Users do not always know where to find services. What are reasonable expectations of service literacy or system literacy? What do patients need to understand about *their* responsibilities if they receive psychotherapy?

Resource optimization

Resources are not necessarily being used most effectively. The publicly funded system, for example, focuses on treating severe cases, yet persistent mental illness is only about two percent of overall demand.

Accountability

Are services uniform? In Australia, there is an assumption that training imposes accountability, but there is no tracking. How *should* accountability be measured and upheld?

Data quality

We need greater clarity about Canadians' mental health service needs and how existing capacity can meet them — starting with agreement on what constitutes "greatest need". Is it addressing problems that have the most extreme impact or those that are most common? And while there is a lack of good-quality data, even data that do exist are not always used because governments, partners and community members are not aware of them or do not know how to use them. There needs to be a clear trail of data extending from the service provider to service planners up through the levels to the top of the government system.

Equity

Is targeting programs to specific groups (e.g., children and youth) possibly discriminatory? On the other hand, is the current model failing certain groups, e.g., those who lose access to services transitioning from youth to adulthood?

Territoriality

Silos exist at all levels of the system — from governments to hospitals to community service providers, between public and private providers — with little or no communication between them. A

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[1] For more information on the Strongest Families program, please visit: http://strongestfamilies.com/

holistic approach is required, one that knocks down the barriers, clarifies accountability and embeds mental health within a health and wellness paradigm.

Systemic stigma

Stigma continues to affect attitudes of service providers within the system, including a lack of belief in recovery. Recovery-oriented system transformation is needed in dialogue with government, and the full range of needs and realities needs to be considered, not just those conspicuous in urban environments.

Tackling the second two questions of the session — *what avenues other than funding should be explored to increase access* and *why are those avenues interesting* — participants noted the following:

Decreasing downstream demand through prevention and promoting wellness

We need to identify and implement a strategic and explicit commitment to wellness promotion across the spectrum. Early intervention and prevention in particular need to be strengthened, e.g., evidence-based mental health promotion in classrooms with young kids. We also need to factor into this what we know about social determinants of health — and fill any gaps.

Adopting person-centred approaches

This starts by engaging people with lived experience in decision making from research onward — asking what they need from the mental health care system. They will give practitioners the guidance they need to provide services in an efficient way. Being person-centred also means embedding supports in the communities where people live, using the language people use to describe their needs (e.g., a suicide prevention service in Waterloo found through Google Analytics that users were searching about "stress" not "suicide"), and taking care to where people are (e.g., the mobile outreach units of the Ontario Telemedicine Network). We need to take the paths not typically taken.

Strengthening mental health literacy

When people are more literate about the system and available services, they can make better choices. This is true of individuals and practitioners — helping people understand "what's on the menu" of services to choose from, and better equipping players within the system to get people in need to the right help. If we do this effectively, will we need gatekeepers anymore or will people be empowered enough to self-assess, describe their needs and find care or help others connect them to care?

Improving systems and pathways to care

We need to look at mental health as a "team sport" that supports multiple pathways to recovery and involves providers and service users equally as co-creators of care. The stepped care model is ideal for this by forging connections among providers and between providers and the community (collaborative systems), and by providing a range of options from generic, universal services to those highly tailored to individual needs, all with their own points of access — allowing service users to step

up and step down to get the level of care they need. Government and regulators have to make sure this kind of flexibility is available — that every door is the right door — and employers can be great allies in getting insurers on board.

Breaking down silos through public–private partnerships

Getting corporations involved, as Bell has done through *Let's Talk*, is key to disseminating a "mental wellness mentality". We need something like a Participaction for mental health, and to involve not just companies but other kinds of organizations like seniors' groups, Boys and Girls Clubs, libraries and more to spread information and help people learn to navigate the system. We also need to work with the courts on diversion approaches.

Technology

Technology — whether e-Mental health apps and services, telemental health services or other offerings — can help increase access by reducing the need for face-to-face consultation and therapy. Trained professionals can act as coaches to guide users in taking advantage of these solutions (rather than requiring the services of specialists, who can then concentrate on those individuals who need their particular skills most). However, technology is a double-edged sword because as soon as funds become available, technology developers scramble for them, and it can be difficult to know which nascent solutions deserve funding.

Innovation and flexibility

We have to stop doing what does not work, start new things that may be better, and continue what we know is working. Communities with non-evidence based programs often keep them going because the programs are low-cost — but they may not work. Are we asking the right research questions or the same questions over and over? We need to look at new models. We need to be more evidence-based, have metrics of success and establish a culture of quality and accountability so every avenue is measurable and can be supported with consistent, sustained funding.

"We should create a funding model to drive the system we want — not the system we have."

~ Participant

Part 3: Funding Approaches

For the day's second working session, participants delved into the pros and cons of insurance and grant funding and explored other possible approaches. The facilitator briefly recapped the strengths and weaknesses of insurance and grant funding from Chodos' presentation and led the group through a structured discussion about each.

Assessing approaches – Part 1

In weighing the relative merits of insurance versus grant funding, many tables cautioned that the following need to be considered:

- Determining accountability
- Promoting equity
- Managing change
- Measuring outcomes
- Assuring quality
- Patient autonomy
- Perpetuating silos
- Driving the system we want, not the one we have

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GUIDING QUESTIONS

1. **Are the major advantages/disadvantages of each funding approach accurately characterized in the charts?**

2. **Are there any other advantages/disadvantages of each funding approach?**

3. **What are the likely challenges or implications to increasing funding using each approach?**

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The groups then discussed whether or not other options might be possible. In their report-backs to the room, participants noted the following as important considerations:

- Determining diagnoses and care pathways
- Factoring how to navigate the system
- Considering context
- Attracting mental health professionals to public practice
- Assessing professional capacity

Discussion in depth

The table discussions generated by the first three questions hit on the following points:

Determining accountability

Both models present challenges of determining accountability and ensuring equity. Given Canada's fragmented health care landscape, it would not be clear who would govern the system, such as

deciding where money goes under the grant funding approach or which professions are eligible for government money through the insurance model.

Promoting equity

The grant funding model may be more suitable for bringing about equity, as it would make it possible to push money out to underserved communities — although providing services in remote areas is more expensive, and it is often difficult to find and retain practitioners.

Managing change

A change management strategy will be necessary regardless of funding approach to align the public, professional bodies and provincial governments with the new scheme. For instance, if additional money is simply funnelled into existing funding vehicles, governments will continue to act the way they always have rather than bring about the changes we want. Who would be responsible for administering a change management strategy is unclear.

Measuring outcomes

Devising a way to generate quality data and measurable, quantifiable outcomes would be essential for any funding approach. We would need a way to measure the new model to know what is working and what is not so we can figure out best practices that can then be applied to other areas.

Assuring quality

Under the insurance funding model, we would need some way to ensure the quality of the service that is being delivered — a challenge because the service providers in the private sector would be from otherwise independent organizations.

Patient autonomy

Is it necessary for funding to go to providers? If funding went to patients directly, this could give them more power to choose where and how they receive the care they need. It would also ensure public dollars are used only as services are used.

Perpetuating silos

The insurance funding model could limit the sharing of information between practitioners as well as treatment continuity for patients. Alternatively, the grant funding model would offer opportunities for team-based practice, which could drive value for dollars across the system and potentially help with more consistent and comparable data collection.

Driving the system we want, not the one we have

Ultimately, both approaches may reinforce the status quo rather than effect change. The goal should be to create a funding mechanism aimed specifically at cultivating a better system. We need to look at innovative models that share the responsibility for funding. Quebec pharmacare is one example of a successful model that expands public-private insurance to cover other sectors.

Following the table report-backs on the first three questions, several participants offered additional perspectives. One cautioned that a fee-for-service arrangement — whether funding goes directly to providers or follows patients — would not do enough to address barriers that marginalize some populations from services. At the same time, paying practitioners on a fee-for-service basis could discourage some from providing services in unstructured settings (e.g., a drop-in model at a community shelter) because there would be no guarantee of remuneration.

Another participant questioned the suitability of the insurance funding model, arguing that such an arrangement would not mesh with the team-based approach to care doctors learn in medical school, which is how they expect their practices to run. Someone else suggested a team approach could be adopted for cases of severe mental disorders while common mental health problems could be suitably dealt with by individual practitioners. "It shouldn't take a full team approach just to make the decision that this person would benefit from having psychotherapy."

> *"Whatever is said to be needed for a person to recover — to become a whole human being again — will there be enough funds to do that for everyone?"*
> *~ Participant*

Assessing approaches – Part 2

On the second set of questions, drilling more into considerations for the grant and insurance funding models and exploring other options, table discussions touched on the following:

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GUIDING QUESTIONS

4. Are there other considerations that neither of these approaches takes into account?

5. Are there ways to address these considerations within either model?

6. Are there other options we need to consider, or even a hybrid option?

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Determining diagnoses and care pathways

Diagnoses and treatment pathways are often clear with physical illnesses and conditions. This is not the case when it comes to mental health, which means physicians would need to be at the centre of the decision making in a diagnosis-driven system. We would need to incorporate clinical practice guidelines and care pathways to ensure quality of service and that any care being delivered is based on evidence.

Navigating the system

Regardless of the system put in place, some kind of system navigation function would be needed to provide a clear, integrated pathway to those trying to access the system.

Considering context

No one funding model is likely to address the full range of needs. There is potential for an approach that adapts to diverse populations and needs, such as a hybrid between the grant and insurance funding models.

Attracting mental health professionals to public practice

It may be hard to convince some practitioners currently working in private practice settings to work in a publicly funded model, particularly if they stand to make less or dislike the working conditions. One idea is to provide free education for mental health professions for a number of years. This could incentivize people to enter those professions, eventually increasing the number in practice. There would also be the potential for a "paradigm shift" in the way mental health care providers are trained, broadening the focus to a team-based approach.

Assessing capacity

This idea resurfaced with the question of how to determine if there is enough public money to cover the delivery of services for everyone who needs them. We have to be able to determine the current capacity, what the needs are and then find a way of assessing each model to figure out if they could fully meet those needs.

"It doesn't matter whether or not mental health care is a necessary service if people are disempowered and not getting what they're entitled to. We need to build a system that makes sense."

~ Participant

Part 4: Additional Policy Considerations

Building on the day's discussions, the group looked beyond the current context to determine which considerations are most important to address — and how to address them. Rather than break out into tables, for this culminating session the full group shared their thinking collectively.

The need for big-picture thinking

In weighing the additional policy considerations related to increasing access to services, participants once again took a largely macro view, identifying systemic changes that could enable meaningful change:

- Making the system smarter
- Building a business case or leveraging existing ones
- Establishing an integrated data strategy
- Targeting mental health care spending
- Getting started

Discussion in depth

The group began by reconfirming that this portion of the discussion should focus on questions of implementation, presuming that people are entitled to psychological services. There was some debate as to whether or not psychological support is guaranteed by the *Canada Health Act* — or at least "medically necessary" services (and what, then, "medically necessary" might mean or if such thinking reintroduces the risk of applying a purely medical model to mental health).

Moving on, the group identified the following as issues that need to be taken into account to increase access:

Making the system smarter

One of the challenges with mental health care is that while we talk about a "system", there is no one system: there are many. This makes it difficult to collect data, measure effectiveness and reinforce accountability — to know if the right services are being delivered by the right people in the right places. There have to be indicators. What is needed is a holistic perspective that considers the determinants of mental wellness (not just the incidence of mental illness) and involves diverse communities in co-creating services and solutions.

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Building a business case or leveraging existing ones

Policymakers need to understand the pros and cons and the value added before they take action. Before signing off on public mental health care services, for example, a provincial minister of health would presumably need have a high level profile of their jurisdiction: who has access to insured benefits and who does not, who has access to private services and who does not, who is supported by an EAP and who is not, etc. We need to know where the gaps are before we can know how to fill them.

Cost-benefit analyses are also key to building the case — and these need to be holistic because, for example, monies being spent in the education sector to keep kids in school may in fact already classify as "mental health dollars", and the same could be true of workplace safety programs, disability insurance programs, etc. Because of this, strategies also need to be cross-governmental and ministries have to stop trying to hold on to their individual budgets in the interest of the greater good.

> ### PUBLIC HEALTH AGENCY OF CANADA
>
> *DATA GATHERING, DATA SHARING*
> Participants recalled that about 15 years ago, PHAC provided a grant for the Government of Canada to consolidate and access insurance company data. The repository was built but participants were unsure how it is being used. In June 2015, PHAC published its first report on mental and anxio-depressive disorders tracked in Canada's chronic disease surveillance system and found that 10 to 15 percent of the population has been treated for anxio-depressive disorders. PHAC is now working on mortality and schizophrenia data. Participants felt this kind of macro data analysis needs to be accelerated and prioritized.

Establishing an integrated data strategy

Currently a lot of the available data is hospital data, but that is not where the majority of services are needed. Provinces and territories have only begun to share data quite recently. They do not always collect information in the same way, so the data are not directly comparable, but there are more similarities than is often thought. Sharing data and setting some common benchmarks is doable.

What indicators do we want nationally, collectively? We should start there and build the data structures to collect the evidence instead of the other way around. It cannot just be about the number of people served; it has to be about outcomes, not system measures. Stigma and access data should be collected, too. At the same time, people need reassurance about data collection: providers are being asked for information by EAP companies, for example. Privacy concerns need to be respected.

Targeting mental health care spending

Do we need to be selective about what we want to accomplish given the scarcity of federal dollars? Choosing a specific population might point the way toward a specific funding strategy, since funding approaches are likely to be population-specific. For example, fee-for-service models make sense for mild to moderate issues, while grant funding is more appropriate to serving marginal populations and reducing inequities.

An insurance plan that bridges the gap between those who have coverage and those who do not could be a useful starting place. While it would not cover everyone, it would be broad enough to provide a kind of "universal" coverage and give everyone access to some services. Those not under the public plan would be under a private plan. As presented by Howard Chodos at the start of the day, 60 percent of Canadians (22.4 million) have some form of private, extended health insurance coverage, but that does not necessarily include mental health care. The insurance industry could look at the questions of how much mental health care is covered.

Drawing on the experience of the Commissaire à la santé et au bien être in Quebec, one participant noted that there are four key questions to address:

1. Econometric modelling of direct fee for service payments to psychotherapy providers vs. GP fundholders' payments to psychotherapy providers
2. Should the insurance model be public, private or hybrid? (actuarial evaluation)
3. How does the system work (e.g., is care prescribed by a physician, a psychologist, a psychotherapist — when do we use specialists? There needs to be a "playbook".)
4. What should be budgeted for health and social services? (Varies by population being targeted.)

Similar to measurement, deciding how to implement should likely start by determining the desired outcomes: what do we want to achieve and how best can we achieve it for a given population, region or area of need?

Getting started

While there is political interest in advancing mental health, there is a gap between that enthusiasm and implementation. The facilitator posed the question, "Is it most important to just start somewhere, with something, even if it's not perfect?"

The key will be to come to agreement about determining need and establishing a clear, evidence-based rationale for choosing a particular starting point. The goal is not just to "save the system money" but also to address service gaps (some not addressed today include better serving the working poor, immigrants, refugees, ethnocultural and racialized populations, rural and remote communities, and First Nation, Inuit and Métis). Again, a holistic perspective is needed to have confidence in the business case, and that business case is likely to vary from province to province, territory to territory. Every region will have views on what makes sense where.

"This is neither the first conversation on this issue nor the last, but having healthy debate is important."

~ Participant

Part 5: Closing Roundtable

Conclusion and next steps

In his concluding remarks, the facilitator restated that consensus on a way forward was not the goal of the session. Rather the intent of the day was to generate ideas that could be used to build on existing initiatives that show promise for improving access.

Rounding out the day, participants shared their reflections on the session. Most felt the session was productive, inspiring and provided ample opportunity for making professional connections. Several touched on directives for future action:

Focus on the outcomes

We will need to measure outcomes to determine if whatever system is put in place is improving not only access but also health outcomes. We need to also look for outcomes that are not overtly about health, such as rates of individuals returning to work or staying in school. While focusing on outcomes is important, we also need to manage expectations, as these changes can take time. Outcomes may even get worse before they improve, as people who were previously unable to access the system begin to trickle in.

Test everything

For any change, we would need pilots to determine if the approach will work as planned. Something like the proposed insurance funding approach, for instance, could be difficult to retract if there are unexpected consequences.

Ensure equity

We need to ensure marginalized populations benefit from any system change that is made. We also need to ensure jurisdictional differences are taken into account. Depending on the adopted approach, some provinces or territories may not have the infrastructure needed to participate.

Fully engage and involve people with lived experience and their families

Ultimately this is about those we serve, not us. Future conversations around system improvements should be made accessible so as to include people with lived experience, who will be able to speak to what they need and what matters to them.

Keep working together

We need to do a better job of learning from each other, sharing what we are doing, what evidence we have, and how we got a particular program up and running. Collaboration needs to happen at the federal level *and* across provinces and territories, although systems may look different.

Ed Mantler thanked participants for sharing their knowledge and expertise, noting that the discussion, work and sharing of ideas "has been incredible". He said that once a report is produced, the MHCC will seek additional guidance and input from stakeholders electronically or through in-person discussions to explore next steps.

APPENDIX A: Meeting agenda

While the agenda shifted during the session, it is included here in its original form for reference. The report covers the day as it actually unfolded.

9:00 a.m. — 4:30 p.m.

Item	Time
Registration	8:15 – 9:00
Welcome and Introductions	9:00 – 9:30
Overview of Considerations (Howard Chodos)	9:30 – 10:15
Break	10:15 – 10:30
Avenues for Expanding Access	10:30 – 12:00
Lunch	12:00 – 12:30
Funding Approaches	12:30 – 14:00
Break	14:00 – 14:15
Additional Policy Considerations	14:15 – 15:30
Moving Forward	15:30 – 16:00
Closing Roundtable	16:00 – 16:30

APPENDIX B: List of participants

NAME	TITLE	ORGANIZATION
Alain Lesage	Psychiatre et Chercheur	Centre de recherche de l'Institut universitaire en santé mentale de Montréal
	Professeur titulaire	Département de psychiatrie, Université de Montréal
Ally Campbell	Youth Advisory Council Representative	Mental Health Commission of Canada
Angela Fowler	Senior Policy Advisor	Children's Mental Health Ontario
Brian McDermid	President	Medical Psychotherapy Association Canada
Chris Summerville	Chief Executive Officer Co-Chair	Schizophrenia Society of Canada – Canadian Alliance on Mental Illness and Mental Health
Fides Coloma	Manager, Mental Health & Addictions Branch	Ontario Ministry of Health & Long Term Care
Fred Phelps	Executive Director	Canadian Association of Social Workers
Gail McVey	Director	Ontario Community Outreach Program for Eating Disorders
Gail Czukar	Chief Executive Officer	Addictions and Mental Health Ontario
Greg Kyllo	National Director, Program Innovation	Canadian Mental Health Association
Ian Boeckh	President	Graham Boeckh Foundation
Ian Manion	Director, Youth Mental Health	The Royal Mental Health – Care & Research
Joan Weir	Director, Health and Disability Policy	Canadian Life and Health Insurance Association
Karen Cohen	Chief Executive Officer	Canadian Psychological Association
Kim Hewitt	Occupational Therapist	Canadian Association of Occupational Therapists
Lisa Crawley	Past President	Canadian Federation of Mental Health Nurses

NAME	TITLE	ORGANIZATION
	Co-Chair	Canadian Alliance on Mental Illness and Mental Health
Lorna Martin	Past President	Canadian Counselling and Psychotherapy Association
Mary Bartram	Researcher/PhD Candidate	School of Public Policy & Administration, Carleton University
Phil Upshall	National Director	Mood Disorders Society of Canada
Rebecca Shields	Chief Executive Officer	Canadian Mental Health Association, York & South Simcoe (for CMHA Ontario)
Rob Moore	Executive Director	Provincial System Support Program at the Centre for Addiction and Mental Health (CAMH)
Shaleen Jones	Executive Director	Peer Support Accreditation and Certification (Canada)
Sharlene Stayberg	Director, Mental Health	Alberta Health
Simon Hatcher	Professor and Vice Chair Research	University of Ottawa Department of Psychiatry/Ottawa Hospital Research Institute
Stephanie Loewen	Director, Mental Health and Spiritual Health Care Branch	Manitoba Health
Stephanie Priest	Director	Health Promotion Chronic Disease Prevention Branch, Public Health Agency of Canada
Victoria Madsen	Territorial Director, Mental Health and Addictions	Government of Nunavut
SPEAKER		
Howard Chodos	Consultant	
MHCC		
Ed Mantler	VP, Programs and Priorities	Mental Health Commission of Canada
Nicholas Watters	Director, Knowledge Exchange	Mental Health Commission of Canada
Christopher Canning	Manager, Policy and Research	Mental Health Commission of Canada
Lara di Tomasso	Research and Policy Analyst	Mental Health Commission of Canada

NAME	TITLE	ORGANIZATION
Lynette Schick	Research and Policy Analyst	Mental Health Commission of Canada
Francine Knoops	Lead Analyst, Strategic Policy and Stakeholder Relations	Mental Health Commission of Canada
MaryAnn Notarianni	Manager, e-Mental Health	Mental Health Commission of Canada
FACILITATORS		
Hugh MacPhie	Principal	MacPhie & Associates
Seth Warren	Associate	MacPhie & Associates