The Time is Now

Considerations for a National Psychotherapy Program

Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

ACKNOWLEDGMENTS

The Mental Health Commission of Canada (MHCC) wishes to thank the members of the Psychotherapy Policy Implementation Network (PPIN) for their commitment, expertise, and support on this collaborative work to increase equitable access to psychotherapies in Canada. A special note of thanks goes to network co-chair Karen Cohen and the steering committee for their leadership and guidance on the PPIN's work and to the working groups for their initiative and efforts to draft the recommendations and collaborate with PPIN members during their finalization.

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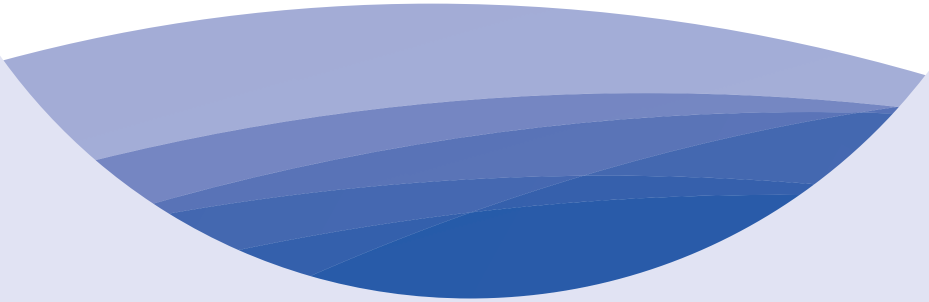

EXECUTIVE SUMMARY

The Psychotherapy Policy Implementation Network (PPIN) was a project created under a two-year contribution agreement between Health Canada and the Mental Health Commission of Canada (MHCC). Its goal was to develop recommendations to inform a future plan for increasing access to psychotherapy in Canada.[1]

The PPIN drew together thought leaders, policy makers, practitioners, people with lived and living experience, key stakeholders in diverse disciplines (e.g., primary care, psychiatry, psychology, social work, and counselling) and the insurance sector from across the country to help with practical options for increasing equitable access to psychotherapies. The PPIN's starting point was a pair of proven models from other jurisdictions: Improving Access to Psychological Therapies (IAPT), a grant-based program in the United Kingdom (U.K.), and the insurance-based Better Access initiative in Australia.

The PPIN working groups explored prospective funding models; considerations related to quality, implementation, and outcome-based treatment; and virtual care — which was especially informed by the COVID-19 context. A fourth working group drafted a PPIN Declaration akin to the U.K.'s *New Savoy Declaration* to articulate its perspective on access to psychotherapies.[2]

The PPIN met three times between February 2020 and February 2021, with numerous intermediate meetings among its steering committee and working groups. Those meetings culminated in members' agreement on a set of recommendations for Health Canada as it considers how to establish an evidence-based, practical, and effective plan to increase access to psychotherapy. This report presents those recommendations.

Recommendations at a glance

Funding Models, Propositions, and Recommendations Working Group

The PPIN proposes two potential funding models for Health Canada's consideration:

1. **Provider based:**

Allocating a fixed amount of annual federal funding to the provinces and territories to expand coverage for the assessment, diagnosis, and/or treatment (i.e., psychotherapy) of mental health disorders within provincial and territorial health systems. This funding would be earmarked for mental health care providers who may not be currently reimbursed through the public health system.

2. **Program based:**

Allocating a fixed amount of annual federal funding to the provinces and territories for an administered program that provides expanded access for the assessment, diagnosis, and/or treatment (i.e., psychotherapy) of mental health disorders.

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[1] More information about the MHCC's previous work on increasing access to psychotherapies is available here.

[2] The full text of the proposed PPIN Declaration begins on page 12.

Quality, Implementation, and Outcome-Based Measurement Working Group

The PPIN puts forward several recommendations related to quality, implementation, and outcome-based treatment within the context of a national psychotherapy program:

Quality

1. Adopt the Quality Mental Health Care Framework in full at the national level. The framework is being developed by the Quality Mental Health Care Network in partnership with HealthCareCAN and the MHCC.
2. Encourage the provinces and territories to develop detailed program-level quality standards to satisfy the framework, based on available best practice standards such as those of IAPT and other leading large-scale psychotherapy initiatives.
3. Ensure that program standards specifically address the needs of individuals at higher risk of not having access to high-quality psychotherapy that offers equal rates of recovery.

Implementation

1. (a) Use implementation science principles and strategies as well as ongoing evaluation to inform implementation. The PPIN working group recommends that implementation efforts leverage select strategies from the Expert Recommendations for Implementing Change (ERIC) project, based on available literature and input from subject matter experts, and (b) use dedicated implementation supports (intermediary, technical assistance, or backbone supports) to inform and support implementation efforts. See Appendix C.
2. Include equity as an integral component of early program development and design, with equity perspectives and expertise represented and included at decision-making tables.
3. Integrate the national psychotherapy program into existing local care pathways.
4. Base the national psychotherapy program on a stepped-care model that includes a range of lower- and higher-intensity[3] services.

Outcome-based treatment

1. Routinely collect and use standardized treatment outcome measures to inform clinical decision making in treatment and for quality improvement, both at the provider/therapist and service/organization levels.
2. Implementation at the local/regional level of a data management platform that is interoperable/compatible among all service providers and accessible to clients.

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[3] That is, the level and frequency of service provider contact.

COVID-19 Considerations and Virtual Care Working Group

The PPIN puts forward recommendations as follows:

Specific to COVID-19:

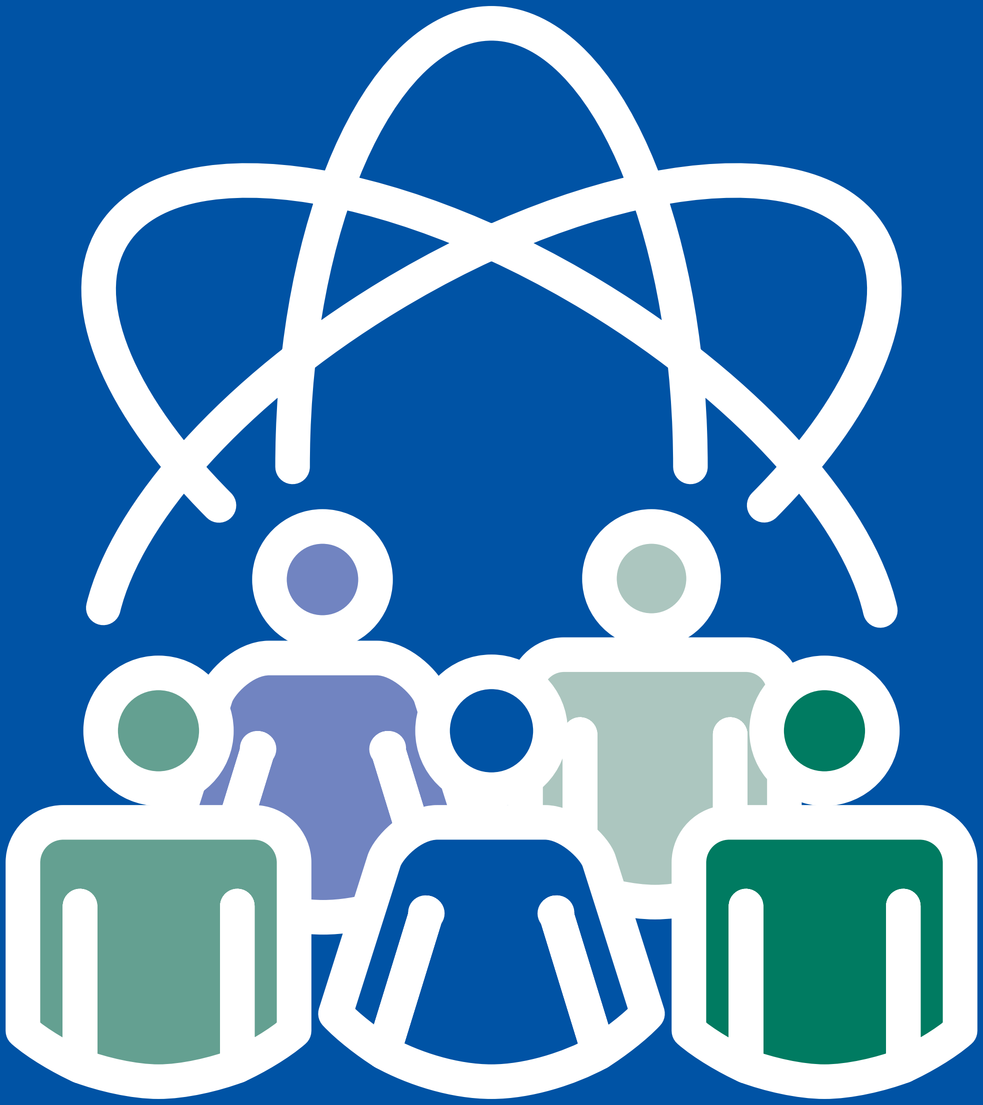
1. Conduct or review a systematic scan of mental health-related pandemic service options such as Stepped Care 2.0 and population-based options. Consider how such initiatives can best be adapted for implementation within provinces and territories.
2. Consider whether provincial/territorial and/or federal efforts to enhance access to mental health services need to be adapted or reconsidered in light of the increased incidence of mental health and substance use concerns people have experienced in living through the pandemic.
3. Survey (or compile results of known surveys of) mental health providers[4] to understand how their practices have changed and may remain changed after the pandemic ends.
4. Survey (or compile results of known surveys of) health-care providers[5] about their mental health while managing the pandemic.

Virtual care more broadly:

1. Identify mental health service gaps in the provinces and territories that fall short of meeting people's needs, while being mindful that there is no one-size-fits-all service that can address all mental health problems.
2. Address stigma and raise mental health service literacy, so people living in Canada know where to turn and who to talk to when they need help.
3. Consider how best to integrate mental health and substance use service options and opportunities into community care.
4. Investigate the standards or safeguards in place to ensure data security, privacy, and confidentiality, which are critical when care is delivered virtually.
5. Address training issues in virtual care for providers and clients, so that privacy, security, confidentiality, and the effectiveness of care can be ensured.

[4] See, for example, COVID-19 and the Mental Health and Substance Use Health Workforce, a study led by Dr. Mary Bartram (MHCC) and Dr. Ivy Bourgeault (University of Ottawa): webinar and infographic.

[5] See, for example, Mental Health Among Health Care Workers in Canada During the COVID-19 Pandemic, from a questionnaire developed by Statistics Canada, in collaboration with Health Canada, the Canadian Institute for Health Information, and the Public Health Agency of Canada. While mental health impacts are significant across the population, there is some evidence to suggest that these impacts are higher in the health-care workforce.



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About the PPIN

ABOUT THE PPIN

In Canada, public funding covers psychotherapies delivered in hospitals, by physicians, or in community services with long waiting lists. But it does not cover those same services when delivered by licensed non-physician providers in private practice (e.g., psychologists, registered psychotherapists, nurses, occupational therapists, social workers). The PPIN was formed around the vision of a Canada where people who need high-quality, evidence-based mental health treatments, supports, or services can access a clinically meaningful course of treatment without any undue financial burden (and with sufficient coverage), just as they can for physical health.

The PPIN was established to achieve three specific outcomes:

Create a pan-Canadian network of mental health leaders and stakeholders dedicated to promoting equitable access to psychotherapy and psychological assessment for all people living in Canada.

Develop recommendations to close current gaps in equitable access based on a decision-making process among members and direction/guidance from the PPIN steering committee.

Seek support across the private and public sectors (including all levels of government) for its recommendations.

The initiative was part of a two-year contribution agreement (April 2019 to March 2021) between Health Canada and the MHCC.

Starting from proven models

The U.K. and Australian governments have each successfully expanded their citizens' access to psychotherapy through publicly funded programs. Those programs served as a basis for the PPIN's consideration of a Canadian solution.

U.K.: Improving Access to Psychological Therapies (IAPT)

The U.K. launched IAPT in 2008 as a nationally administered, grant-based program free to all clients. It features a specially trained workforce and is strongly focused on quality through clear targets backed by intensive performance monitoring. The program is oriented toward adults with mild-to-moderate depression and/or anxiety and also features stepped care. Today, IAPT is expanding to address mental health issues in children and youth, comorbid physical health problems, and severe mental illness.

Australia: Better Access

This insurance-based program requires patients to be referred by a general medical practitioner (GP) and allows for copays. As of 2019, the program had registered 22,577 psychologists and allied health professionals (social workers, occupational therapists, and nurses), who offer psychological services under a medicare benefits schedule. The latest Australian annual report shows that 1.4 million individuals have received close to 5.9 million mental health services under this program. Quality is evaluated by regulated professional associations. New telehealth options are expanding access to psychotherapy in rural areas.

The PPIN: Formation and components

The MHCC formed an interim steering committee in August 2019 to develop Terms of Reference and create the PPIN. The group of advisory thought leaders assembled to inform its development at that time was later absorbed into PPIN membership.

Once the PPIN was established in the winter of 2020, a formal steering committee was struck. Both the steering committee and PPIN overall were co-chaired by Maureen Abbott, manager of the MHCC's Access to Quality Mental Health Services team, and Dr. Karen Cohen, CEO of the Canadian Psychological Association.

The PPIN's members represented a wide range of perspectives from the mental health stakeholder community, who came together to share their knowledge, identify challenges and opportunities related to expanding access, and vote on recommendations co-developed with the PPIN's working groups.

Overview: Working groups

Declaration working group

The U.K.'s IAPT program was spurred by the *New Savoy Declaration*, a call that rallied organizations and champions from government and academia to advocate together for better access to psychotherapy. The PPIN Declaration working group developed a similar document, presenting an initial draft at the February 2020 meeting. The revised version presented at the November 2020 meeting was accepted by 94 per cent of PPIN members.

Psychotherapy Policy Implementation Network (PPIN) Declaration

We believe in parity for mental and physical health. This means demonstrating equal concern for mental and physical health problems by providing comparable access to care and services for both across all health systems.

Despite focused public and private investments in mental health in recent years, Canada still has a long way to go to achieve parity of mental and physical health. Many Canadians experiencing mental health problems do not have timely access to mental health services, with access to psychotherapy constituting one of the most significant gaps in parity today.

Psychotherapies represent a range of psychological approaches to treating many mental health problems. Psychotherapies support people of all backgrounds and all ages in their journeys of recovery. However, there is not equitable access to these proven, front-line treatments because not all qualified providers of psychotherapy are eligible for public funding.

In Canada, psychotherapy is publicly funded only when it is provided by physicians, in hospitals, or in community services with long waiting lists. At the best of times, these sources of psychotherapy are unable to meet the needs of all Canadians.

Fortunately, there are many other qualified providers of psychotherapy, such as psychologists, social workers, psychotherapists, counselling therapists and others. Unfortunately, unless they are working in hospitals or in community settings funded by government, their services are not eligible for public funding. While those with employment-based health insurance may be able to access some psychotherapy services, they cannot always rely on their benefits to provide adequate care.

This means that the hundreds of thousands of people in Canada who cannot afford private psychotherapy services will not receive the treatment they require. Help for people is out there, but unlike physical care, it is not accessible to everyone who needs it.

Over the past decade, the United Kingdom and Australia have both demonstrated that increased public funding can ensure better access to mental health care psychotherapy. The kinds of policies that worked in these countries can work in Canada as well.

All levels of government, private insurers as well as providers of mental health care need to work together to ensure that everyone who can benefit from psychotherapy is able to access these services when and where they need them.

We commit to doing our part to build up integrated and high-quality psychotherapy provision that is appropriately regulated. We will explore and propose innovative funding and delivery solutions that will promote equitable access to psychotherapy across Canada. Together, we will strive to make these services safe, effective, and successful in improving mental well-being, fighting stigma, and reducing health inequalities.

The time for parity for mental and physical health is now.

Funding models, propositions, and recommendations working group

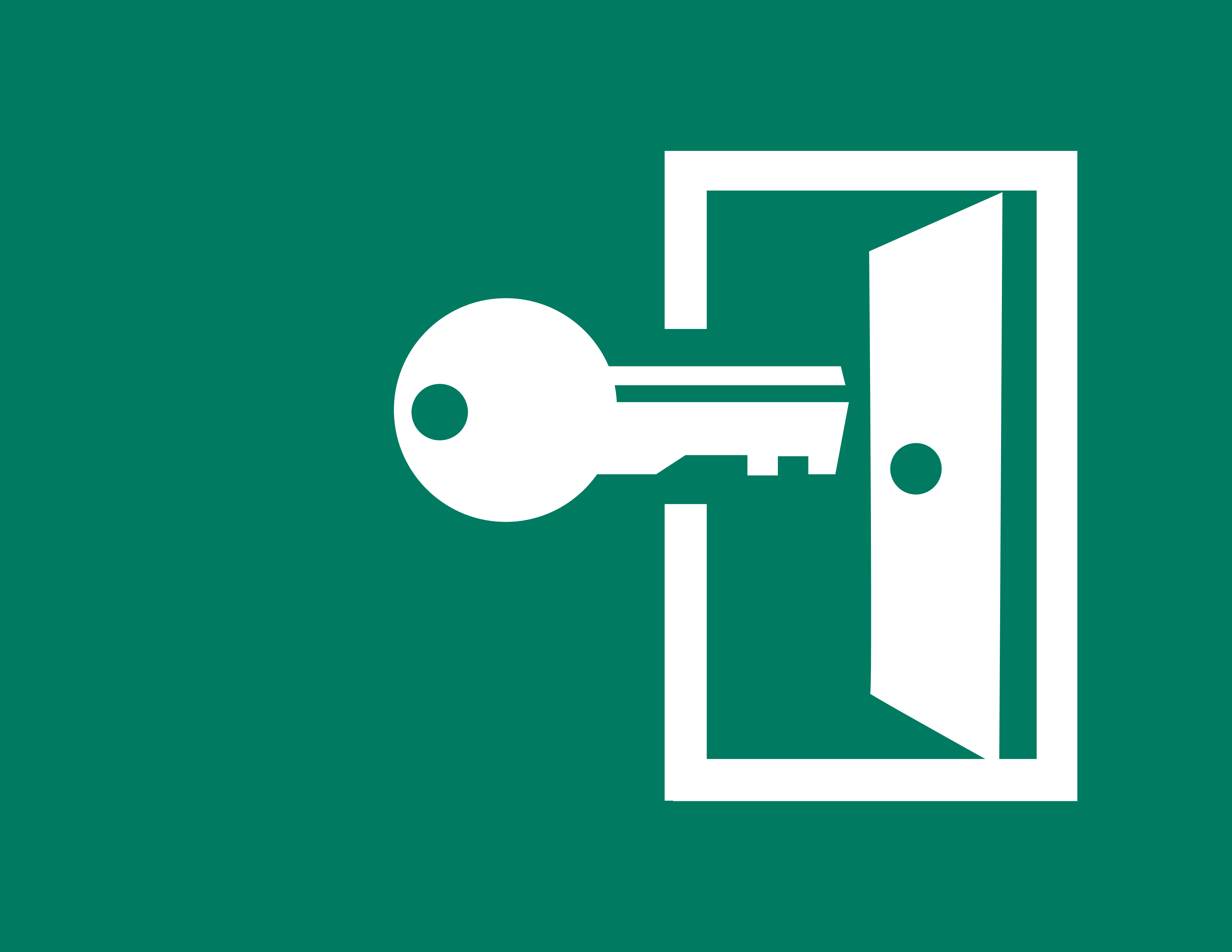
This group met regularly between September 2020 and January 2021 to develop two options for a federally funded national psychotherapy initiative (provided below). These were put forward in *Two Roads… to Increase Access to Psychotherapy in Canada*. This document presented as much detail as possible to help the PPIN evaluate both options while allowing for the flexibility required to implement either across jurisdictions. In February 2021, PPIN members accepted the group's recommendations.

Quality, implementation, and outcome-based treatments working group

This group worked to develop a common understanding of "quality," "implementation," and "outcome-based treatments" in the context of a national psychotherapy program. Between September 2020 and January 2021, the group met regularly to draft and revise its recommendations based on existing literature, other resources, and feedback from the PPIN. In February 2021, PPIN members accepted the group's recommendations.

COVID-19 considerations and virtual care working group

This group investigated the extent to which e-mental health services could increase access to psychotherapy in Canada during the COVID-19 pandemic and beyond. Members examined services currently available in Canada and considered broader questions of accessibility, digital literacy among practitioners and clients, mental health service literacy among clients, privacy and security, inter-provincial and territorial regulation, and the integration of e-mental health services into primary care. In February 2021, PPIN members accepted the group's recommendations.



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Recommendations: Two roads to expand access to psychotherapy

RECOMMENDATIONS: TWO ROADS TO EXPAND ACCESS TO PSYCHOTHERAPY

Funding models working group

Throughout the PPIN meetings, questions about funding centred on the feasibility of a federal insurance fund and what such a fund could potentially accomplish. Discussions touched on the structure of the health system's jurisdictional issues, administrative requirements, and intersections with private insurance, along with the appropriateness of a fee-for-service model in the context of equitable access to psychotherapy and the complexity of cross-country implementation.

The funding models working group, struck after the February 2020 meeting, held focused discussions on a national psychotherapy fund and deliberated on two potential models of federal funding to the provinces and territories: (1) annual provider-based funding to expand coverage for assessment, diagnosis, and/or treatment, and (2) program-based funding for an administered program to provide expanded access for assessment, diagnosis and/or treatment. After these were progressively refined, the group ultimately recommended that versions of both options be put forward for Health Canada to consider.

Provider-based funding model

A fixed amount of annual federal funding allocated to the provinces and territories to expand coverage for the assessment, diagnosis, and/or treatment (i.e., psychotherapy) of mental health disorders within provincial and territorial health systems. The funding would be earmarked for mental health care providers who may not be currently reimbursed through the public health system.

Considerations

Eligibility.

Should the fund be extended to all residents of a province/territory, made available to specific populations, or used for specific mental health disorders or problems (e.g., depression, anxiety, first episode psychosis)?

Accessibility.

Would access to a mental health care provider require a referral from a physician? To promote overall continuity of care and system integration, would a treatment plan and report be sent to a patient's/client's family physician with consent?

Evidence.

With ample evidence on the effectiveness of psychotherapy, including how many sessions are necessary (on average) for successful outcomes, the number of sessions covered under a provider-based model should reflect this.

Covered providers.

Given that this model is provider based, its expansion should consider public protection in the services it covers. In health care, this is typically ensured through regulation. Coverage should also be limited to providers whose scope of practice includes mental health assessment, psychotherapy, and/or diagnosis. Issues to be addressed: which providers will be covered, and how will public protection (typically done through the regulation of health-care providers) be ensured?

Provider reimbursement.

Provinces and territories would determine how best to reimburse mental health care providers (e.g., fee-for-service model, salary, blended, capitation, sessional) for the provision of evidence-based mental health care services.

Public funding and private insurance.

What impacts would publicly funded coverage have on current employer-sponsored extended health benefits? Should these extended health benefits be exhausted before individuals access publicly funded mental health care? Should employers be mandated to provide a certain level of coverage for mental health services (bearing in mind the amount of care typically required for successful therapy outcomes)? Should public funding be made available only to those without access to other forms of insurance coverage?

Copayment.

Should eligible residents receive first-dollar coverage or require a copayment?

System performance.

Have the appropriate mental health-system indicators been developed to evaluate and report out on its performance?

Provider-based funding model

A fixed amount of annual federal funding allocated to the provinces and territories for an administered program that provides expanded access for the assessment, diagnosis, and/or treatment (i.e., psychotherapy) of mental health disorders.

Considerations

All the same questions and considerations associated with the provider-based model apply to the program-based model, with the following exceptions:

Evidence-based care.

Structured programs are typically organized to deliver specific content in specific ways over a specific period of time and number of sessions. How many sessions would depend on the evidence base, the program's eligibility criteria, and the specific disorder(s) or population(s) being addressed. Care should be organized according to a stepped model, with low- and high-intensity[6] options that patients/clients can access as they need to without medical referral.

Provision of care.

Two sets of considerations apply:

- **Standardized services:** Programmatic approaches to care are typically standardized (e.g., the U.K.'s IAPT program). Should standardized methods of screening, assessment, triage, treatment delivery, and measurement-based care be implemented — with customization for specific mental health disorders or populations? It is a principle of health care in Canada that there be public protection mechanisms for the services being delivered.
- **Providers:** In a programmatic model, care may be delivered by regulated mental health care providers (e.g., high-intensity care) or under the supervision of regulated providers (e.g., low-intensity care). The latter are often responsible for evaluating patient/client and program outcomes.

Training.

What kinds of resources would be needed to ensure that those delivering care are consistently and systematically trained in the evidence-based care a program is based on?

Public funding and private insurance.

Would the introduction of a new program for psychotherapy have (unintended) impact(s) on the range of employer-sponsored extended health benefits offered to employees?

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[6] That is, the level and frequency of service provider contact.

Federal, provincial, and territorial responsibilities

Regardless of which model is chosen, the PPIN proposes that the federal government establish a multi-year fiscal framework, subject to renewal. Funding would be allocated to the provinces and territories on an equal per capita basis. A formal evaluation of the fund would commence after the third year and inform any future discussion about the structure/funding of the program. If the fund meets its objectives, there could be future discussions between the federal and provincial/territorial governments about expanding its coverage beyond specific populations or mental health disorders.

Provinces and territories receiving the funding would provide detailed action plans and agree to publicly report on the performance of the funds each year, with a specific focus on indicators that include number of services, quality of care, health outcomes, and patient/client and provider satisfaction.

4

Recommendations for quality, successful implementation, and outcome-based measurement

RECOMMENDATIONS FOR QUALITY, SUCCESSFUL IMPLEMENTATION, AND OUTCOME-BASED MEASUREMENT

Quality, implementation, and outcome-based measurement working group

PPIN members agreed that funding, quality, and implementation should be considered together and evaluated over the long term (e.g., 20 years), as each has implications affecting the other.[7] A starting point for the working group was to establish clear parameters for "quality," "implementation," and "outcome-based measurement," so jurisdictions could focus on implementing high-quality, equitable programs.

The group arrived at the following understanding to guide its work:

Quality.

High level — encompasses program objectives, goals, and guiding principles. Implementation level — is expressed through program standards.

Implementation.

Encompasses the "methods or techniques used to enhance the adoption, implementation, and sustainment of a program or practice" (p. 2).[8]

Outcome-based measurement.[9]

The practice of basing clinical care on client data collected throughout treatment (i.e., routine client-level data collection to inform clinical decision-making).

With respect to quality, the working group focused on the dimensions of the Quality Mental Health Care Framework (see Appendix A) being developed by the Quality Mental Health Care Network, in partnership with HealthCareCAN and the MHCC. According to the framework, psychotherapy should be accessible and appropriate; involve continuous learning and improvement; be integrated across the care continuum; be people-centred, recovery-oriented, safe, stigma-free, inclusive, and trauma informed; and account for a healthy work life environment that supports provider wellness and promotes psychological safety.

While the group recognized that a variety of frameworks exist to guide implementation, broadly speaking, implementation science has three aims: (1) to describe the process of translating research into practice (process models), (2) to understand what influences implementation outcomes (determinant frameworks, classic theories, implementation theories[10]), and (3) to evaluate the implementation of interventions (evaluation frameworks). The group's position, that multiple implementation strategies should be selected based on a thorough understanding of context, is reflected in its ultimate recommendations.

With respect to outcome-based measurement, the working group determined (in collaboration with PPIN members) that multiple levels of outcomes need to be tracked, both at the clinical level (i.e., for individuals) and the population level.

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[7] At the February 2021 meeting, many PPIN members recommended that new funding be linked to program performance outcomes.

[8] Bunger, A. C., Powell, B. J., Robertson, H. A., MacDowell, H., Birken, S. A., & Shea, C. (2017). Tracking implementation strategies: A description of a practical approach and early findings. *Health Research and Policy Systems*, 15. Article 15, 1-12. https://doi.org/10.1186/s12961-017-0175-y

[9] Used interchangeably with measurement-based care and routine outcome monitoring.

[10] Determinant frameworks identify determinants that influence implementation outcomes. Classic theories, unlike implementation theories, arise outside implementation science and provide understanding for some of its aspects. See Table 1 in "Making Sense of Implementation Theories, Models and Frameworks," by Per Nilson, 2015, *Implementation Science*, 10, Article 53. https://doi.org/10.1186/s13012-015-0242-0.

Recommendations

Quality.

1. Adopt the Quality Mental Health Care Framework in full at the national level. The framework defines quality mental health care and the essential dimensions that encompass the provision of quality mental health care.

2. Encourage each province and territory to develop more detailed program-level standards to meet the quality framework requirements identified. These quality standards should be informed by best practices from comparable and leading large-scale psychotherapy initiatives, such as the U.K.'s IAPT (see Appendix B).

3. Strive for equity by having program standards account for the needs of individuals who are at higher risk of not having access to the kind of high-quality psychotherapy that offers equal rates of recovery. The MHCC's 2018 report, *Expanding Access to Psychotherapy: Mapping Lessons Learned from Australia and the United Kingdom to the Canadian Context,* emphasizes the opportunity Canada has to reduce the experiences of inequities in access and outcomes. Select examples include

- combining universal approaches with targeted programming to promote equitable uptake
- using specific equity targets to hold programs accountable for equitable outcomes
- including people with substance use disorders, who may well benefit from psychotherapy services
- engaging people with lived and living experience in the design and delivery of services.

Implementation.

1. Use implementation science principles and strategies as well as ongoing evaluation to inform implementation. The working group recommends that implementation efforts leverage select strategies from the Expert Recommendations for Implementing Change (ERIC) (see Appendix C), based on available literature and input from subject matter experts. Dedicated implementation supports (intermediary, technical assistance, or backbone supports) should be used to inform and support implementation efforts.

2. Include equity as an integral component of early program development and design, with equity perspectives and expertise represented and included at decision-making tables. In addition, linking population and service data to the development of the program provides an opportunity to identify (a) rates of problems experienced, (b) who is or is not being served, (c) who is or is not accessing current services, each with a view to targeting service development and delivery to those who are not receiving adequate care.

3. Integrate the national psychotherapy program into existing local care pathways. Formally connecting services to the broader mental health and health-care systems should support initial screening, referral, medication management, and the ongoing or longer-term management of mental health concerns and other comorbid conditions, as well as specialized services and other supports for patients/clients that require services beyond psychotherapy. Such a connection includes formal partnerships with local community-based services and primary care services to support effective communication on shared patients/clients, efficient referral pathways, and clear discharge pathways for ongoing and/or longer-term patient/client needs outside the scope of psychotherapy.

4. Base the national psychotherapy program on a stepped-care model that includes a range of lower- and higher-intensity services. Patients/clients should initiate treatment at the lowest appropriate level of treatment intensity based on their preference, readiness, unique circumstances, and needs.

Outcome-Based Treatment.

1. Routinely collect and use standardized treatment outcome measures to inform clinical decision making throughout treatment and quality improvement, both at the provider/therapist and service/organization levels. The minimum datasets and other data collection and evaluation frameworks from IAPT and other relevant large-scale psychotherapy initiatives should be consulted. In addition, measures should go beyond deficits to include engagement, strengths, functioning, wellness, and readiness.

2. Implement at the local/regional level of a data management platform that is interoperable or compatible among all service providers and accessible to patients/clients. The session-by-session collection and use of routine outcome measures should be facilitated by a data management platform.

Framework

Dimensions of Quality Mental Health Care

5

Recommendations: New digital options for increased access

RECOMMENDATIONS: NEW DIGITAL OPTIONS FOR INCREASED ACCESS

COVID-19 considerations and virtual care working group

The working group focused on the ways virtual care offers an easy-to-use and low-cost means of expanding access to psychotherapy, particularly in light of the limits on in-person interactions brought on by COVID-19. At the same time, the group considered the relative applicability and effectiveness of digital solutions and the need for digital training, literacy, privacy, and security for providers and patients alike.

Recommendations specific to COVID-19

1. Conduct or review a systematic scan of mental health-related pandemic service options such as Stepped Care 2.0 and population-based options. Consider how such initiatives can best be adapted for imple-mentation within provinces and territories.
2. Consider whether provincial/territorial and/or federal efforts to enhance access to mental health services need to be adapted or reconsidered in light of the increased incidence of mental health and substance use concerns people have experienced in living through the pandemic.
3. Survey (or compile results of known surveys of) mental health providers to understand how their practices have changed and may remain changed after the pandemic ends.
4. Survey (or compile results of known surveys of) health-care providers about their mental health while managing the pandemic.

Recommendations on virtual care more broadly

1. Identify mental health service gaps in the provinces and territories that fall short of meeting people's needs, while being mindful that there is no one-size-fits-all service that can address all mental health problems.
2. Address stigma and raise mental health service literacy, so people living in Canada know where to turn and who to talk to when they need help.
3. Consider how best to integrate mental health and substance use service options and opportunities into community care.
4. Investigate the standards or safeguards in place to ensure data security, privacy, and confidentiality, which are critical when care is delivered virtually.
5. Address training issues in virtual care for providers and patients/clients so that privacy, security, confidentiality, and the effectiveness of care can be ensured.

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Appendices

A

Quality Mental Health Care Framework

HealthCareCAN and the Mental Health Commission of Canada (MHCC) have been working together for over three years to advance mental health in the workplace for the health-care sector. Together, they led the By Health, For Health Collaborative (the Collaborative), a group of leaders representing over 20 healthcare organizations across Canada who are committed to advancing psychological health and safety in health care.

The Collaborative had a vision for healthcare workplaces to be leaders and role models in providing psychologically healthy and safe environments for all people in Canada. It successfully championed a shift in the healthcare industry to focus on mental health in the workplace, including having the implementation of the National Standard of Canada for Psychological Health and Safety in the Workplace recognized within healthcare organizations as a leading practice by the Health Standards Organization (HSO).

Building on the success of the Collaborative and its initiatives, HealthCareCAN and the MHCC now co-lead the Quality Mental Health Care Network (QMHCN), which unites health sector leaders from across the country in an effort to remove barriers hindering access to high-quality mental health services. The QMHCN addresses structural stigma, promotes recovery-oriented practice, and furthers the work of the Collaborative by continuing to support psychologically healthy and safe workplaces in health care. This includes enabling recovery-oriented practice, addressing stigma, and improving access to quality mental health care across Canada.

HealthCareCAN is leading the development of a Quality Mental Health Care Framework (the Framework), a key initiative by the QMHCN. The Framework defines quality mental health care and the essential quality dimensions that encompass its provision.

Building the quality mental health care framework

To inform the development of the Framework, HealthCareCAN and the MHCC conducted an environmental scan and reviewed existing provincial and territorial, national, and international quality-care frameworks to identify where the language and concepts of mental health, stigma, and recovery are missing or overlooked.

HealthCareCAN also interviewed QMHCN members and subject matter experts in mental health and research — including HealthCareCAN members, Canadian Patient Safety Institute (CPSI), Royal College of Physicians and Surgeons of Canada, The Royal Mental Health Centre, and Waypoint Centre for Mental Health Care.

HealthCareCAN and the MHCC jointly held focus groups with the MHCC's Youth Council and Hallway Group, while HealthCareCAN led a focus group with Patients for Patient Safety Canada to engage and connect directly with people with lived experience (PWLE).

The key informant interviews identified many vital aspects of quality mental health care, including people centred, equitable, safe, evidence-based, appropriate, accessible, and timely care. The PWLE further validated and informed the framework, identifying that it must consider the impact of the social determinants of health, alternative therapies, trauma and violence, and inclusivity as well as address the need to be culturally appropriate, culturally safe, and culturally sensitive.

The environmental scan and the key informant interviews identified the HSO/CPSI *Canadian Quality and Patient Safety Framework for Health and Social Services* as the most relevant for this project. This framework is evidence-based, well-known in Canada, and recognizes healthcare workers specifically.

What is quality mental health care?

A thorough review of the selected frameworks that address quality health care, interviews with health experts, and insights from PWLE led to a definition and identification of critical dimensions that encompass quality mental health care, emphasizing both patient and provider perspectives.

Quality mental health care is:

Accessible, appropriate, promotes continuous learning and improvement, integrated, people-centred, recovery-oriented, safe, stigma-free and inclusive, trauma-informed, and ensures that health care providers have a safe and comfortable workplace environment.

Figure 1: Framework Dimensions of Quality Mental Health Care

Dimension	Description
Accessible	Having timely and equitable care across the continuum. Promotes prevention and early intervention. Community-based interventions are available.
Appropriate	Care is evidence informed and culturally competent.
Continuous learning and improvement	Knowledge sharing and capacity building among members of the health-care workforce. Innovative care is encouraged and supported.
Integrated	Care is continuous across the continuum. Transition into community settings is smooth. The family's and/or patient's support system is involved. Integration with services that address social determinants of health.
People-centred	Care is focused and organized around the health needs and expectations of people and communities rather than on disease.
Recovery-oriented	Living a satisfying, hopeful, and meaningful life, even when there may be ongoing limitations related to mental health problems and illnesses.
Safe	Keeping people and providers safe from preventable harm. Care is culturally safe for individuals and marginalized populations.
Stigma-free and inclusive	Care addresses drivers of mental health stigma and prevents stigma practices in mental health care. Healthcare providers are comfortable in coming forward with their mental health problems and illnesses at work. Addresses multiple layers of stigma (individual, interpersonal, intersectoral, and structural). A need to better support individuals who have experienced stigma and discrimination. Individuals feel respected and valued.
Trauma-informed	Recognizes the impacts of trauma and violence on individuals receiving mental health care services.
Worklife environment	A healthy workplace environment supports provider wellness and promotes psychological safety.

B

IAPT standards[11]

Service model

- Services should offer a stepped care model that provides patients the appropriate level of care for their needs.
- Services should include employment advisors or work closely with such advisors.
- Joint commissioning of high and low intensity interventions within IAPT should ensure seamless transition of patients within the stepped care model. Commissioning should also aim to develop coherent care pathways linking IAPT with other mental health provision.
- Services should have a clear focus, capability and capacity to safely manage severe and complex cases.

Access

- Services should focus on prompt access and equity of access for the harder-to-reach local community, such as older people and the long-term unemployed.
- Services should seek to expand self-referral and ensure promotion and marketing to different sections of the community.
- Patients should have a choice of therapy according to preference, choice of when and where to be seen, plus how NICE recommended treatments are delivered (eg. individual, group, via telephone etc.) when appropriate. Arrangements should be mutually agreed between patient and therapist as part of good care planning.

Treatment

- Service users should receive patient centered assessments (problems and goals, employment issues) plus a provisional diagnosis, and cluster assignment if agreed locally, at intake, with subsequent regular progress reviews.
- Treatments should be NICE recommended and evidence based, offered in the appropriate dosage by a trained and accredited workforce.
- Consistent arrangements for liaison with GPs at discharge and routine follow up where indicated should be in place.

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[11] Cited from **https://mentalhealthpartnerships.com/wp-content/uploads/sites/3/iapt-for-adults-minimum-quality-standards.pdf.**

Outcomes data collection

- A minimum of 90% data completeness for pre/post treatment scores should be achieved from all patient contacts.
- IT systems should enable therapists and service directors to have prompt access to outcomes data and to generate service reports.
- Routine outcomes data measurement should be used to inform regular clinical supervision (see below) and to improve service quality and accountability.
- To effectively operate a stepped care service it is essential that patients can be tracked through the full stepped care pathway through an inter-operable IT system.

Workforce education and training

- Services should aim to develop a balanced workforce in relation to local needs, i.e. in terms of skill mix for different modalities and levels to offer best matched care according to patient preference, as well as clinical background, gender, ethnicity etc. to offer culturally acceptable options.
- Services should have a stable core of trained and accredited therapists (by an appropriate accreditation organization for psychological therapists offering NICE-approved treatments) who represent a mix of seniority across the different therapeutic modalities and can support IAPT trainees in their clinical development.
- Services should have sufficient therapists trained to deliver high intensity and low intensity treatments.
- Therapists (experienced and trainees) should receive regular and appropriate outcomes informed supervision; continued professional development; access to appropriate clinical facilities (e.g. clinic rooms, digital recording, telephones, IT systems) and opportunities to see a mixed caseload including some patients who present with mild or moderate symptoms. Workloads should be consistent with professional and ethical guidelines for sustainable quality of care.
- Staff turnover should be monitored, e.g. via “exit interviews.”

C

ERIC strategies[12]

Strategy	Definitions
Access new funding	Access new or existing money to facilitate the implementation
Alter incentive/allowance structures	Work to incentivize the adoption and implementation of the clinical innovation
Alter patient/consumer fees	Create fee structures where patients/consumers pay less for preferred treatments (the clinical innovation) and more for less-preferred treatments
Assess for readiness and identify barriers and facilitators	Assess various aspects of an organization to determine its degree of readiness to implement, barriers that may impede implementation, and strengths that can be used in the implementation effort
Audit and provide feedback	Collect and summarize clinical performance data over a specified time period and give it to clinicians and administrators to monitor, evaluate, and modify provider behavior
Build a coalition	Recruit and cultivate relationships with partners in the implementation effort
Capture and share local knowledge	Capture local knowledge from implementation sites on how implementers and clinicians made something work in their setting and then share it with other sites
Centralize technical assistance	Develop and use a centralized system to deliver technical assistance focused on implementation issues
Change accreditation or membership requirements	Strive to alter accreditation standards so that they require or encourage use of the clinical innovation. Work to alter membership organization requirements so that those who want to affiliate with the organization are encouraged or required to use the clinical innovation
Change liability laws	Participate in liability reform efforts that make clinicians more willing to deliver the clinical innovation
Change physical structure and equipment	Evaluate current configurations and adapt, as needed, the physical structure and/or equipment (e.g., changing the layout of a room, adding equipment) to best accommodate the targeted innovation

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[12] Cited from https://implementationscience.biomedcentral.com/track/pdf/10.1186/s13012-015-0209-1.pdf.

Change record systems	Change records systems to allow better assessment of implementation or clinical outcomes
Change service sites	Change the location of clinical service sites to increase access
Conduct cyclical small tests of change	Implement changes in a cyclical fashion using small tests of change before taking changes system-wide. Tests of change benefit from systematic measurement, and results of the tests of change are studied for insights on how to do better. This process continues serially over time, and refinement is added with each cycle
Conduct educational meetings	Hold meetings targeted toward different stakeholder groups (e.g., providers, administrators, other organizational stakeholders, and community, patient/consumer, and family stakeholders) to teach them about the clinical innovation
Conduct educational outreach visits	Have a trained person meet with providers in their practice settings to educate providers about the clinical innovation with the intent of changing the provider's practice
Conduct local consensus discussions	Include local providers and other stakeholders in discussions that address whether the chosen problem is important and whether the clinical innovation to address it is appropriate
Conduct local needs assessment	Collect and analyze data related to the need for the innovation
Conduct ongoing training	Plan for and conduct training in the clinical innovation in an ongoing way
Create a learning collaborative	Facilitate the formation of groups of providers or provider organizations and foster a collaborative learning environment to improve implementation of the clinical innovation
Create new clinical teams	Change who serves on the clinical team, adding different disciplines and different skills to make it more likely that the clinical innovation is delivered (or is more successfully delivered)
Create or change credentialing and/or licensure standards	Create an organization that certifies clinicians in the innovation or encourage an existing organization to do so. Change governmental professional certification or licensure requirements to include delivering the innovation. Work to alter continuing education requirements to shape professional practice toward the innovation
Develop a formal implementation blueprint	Develop a formal implementation blueprint that includes all goals and strategies. The blueprint should include the following: 1) aim/purpose of the implementation; 2) scope of the change (e.g., what organizational units are affected); 3) timeframe and milestones; and 4) appropriate performance/progress measures. Use and update this plan to guide the implementation effort over time
Develop academic partnerships	Partner with a university or academic unit for the purposes of shared training and bringing research skills to an implementation project

Develop an implementation glossary	Develop and distribute a list of terms describing the innovation, implementation, and stakeholders in the organizational change
Develop and implement tools for quality monitoring	Develop, test, and introduce into quality-monitoring systems the right input—the appropriate language, protocols, algorithms, standards, and measures (of processes, patient/consumer outcomes, and implementation outcomes) that are often specific to the innovation being implemented
Develop and organize quality monitoring systems	Develop and organize systems and procedures that monitor clinical processes and/or outcomes for the purpose of quality assurance and improvement
Develop disincentives	Provide financial disincentives for failure to implement or use the clinical innovations
Develop educational materials	Develop and format manuals, toolkits, and other supporting materials in ways that make it easier for stakeholders to learn about the innovation and for clinicians to learn how to deliver the clinical innovation
Develop resource sharing agreements	Develop partnerships with organizations that have resources needed to implement the innovation
Distribute educational materials	Distribute educational materials (including guidelines, manuals, and toolkits) in person, by mail, and/or electronically
Facilitate relay of clinical data to providers	Provide as close to real-time data as possible about key measures of process/outcomes using integrated modes/channels of communication in a way that promotes use of the targeted innovation
Facilitation	A process of interactive problem solving and support that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship
Fund and contract for the clinical innovation	Governments and other payers of services issue requests for proposals to deliver the innovation, use contracting processes to motivate providers to deliver the clinical innovation, and develop new funding formulas that make it more likely that providers will deliver the innovation
Identify and prepare champions	Identify and prepare individuals who dedicate themselves to supporting, marketing, and driving through an implementation, overcoming indifference or resistance that the intervention may provoke in an organization
Identify early adopters	Identify early adopters at the local site to learn from their experiences with the practice innovation
Increase demand	Attempt to influence the market for the clinical innovation to increase competition intensity and to increase the maturity of the market for the clinical innovation
Inform local opinion leaders	Inform providers identified by colleagues as opinion leaders or “educationally influential” about the clinical innovation in the hopes that they will influence colleagues to adopt it
Intervene with patients/consumers to enhance uptake and adherence	Develop strategies with patients to encourage and problem solve around adherence

Involve executive boards	Involve existing governing structures (e.g., boards of directors, medical staff boards of governance) in the implementation effort, including the review of data on implementation processes
Involve patients/consumers and family members	Engage or include patients/consumers and families in the implementation effort
Make billing easier	Make it easier to bill for the clinical innovation
Make training dynamic	Vary the information delivery methods to cater to different learning styles and work contexts, and shape the training in the innovation to be interactive
Mandate change	Have leadership declare the priority of the innovation and their determination to have it implemented
Model and simulate change	Model or simulate the change that will be implemented prior to implementation
Obtain and use patients/consumers and family feedback	Develop strategies to increase patient/consumer and family feedback on the implementation effort
Obtain formal commitments	Obtain written commitments from key partners that state what they will do to implement the innovation
Organize clinician implementation team meetings	Develop and support teams of clinicians who are implementing the innovation and give them protected time to reflect on the implementation effort, share lessons learned, and support one another's learning
Place innovation on fee for service lists/formularies	Work to place the clinical innovation on lists of actions for which providers can be reimbursed (e.g., a drug is placed on a formulary, a procedure is now reimbursable)
Prepare patients/consumers to be active participants	Prepare patients/consumers to be active in their care, to ask questions, and specifically to inquire about care guidelines, the evidence behind clinical decisions, or about available evidence-supported treatments
Promote adaptability	Identify the ways a clinical innovation can be tailored to meet local needs and clarify which elements of the innovation must be maintained to preserve fidelity
Promote network weaving	Identify and build on existing high-quality working relationships and networks within and outside the organization, organizational units, teams, etc. to promote information sharing, collaborative problem-solving, and a shared vision/goal related to implementing the innovation
Provide clinical supervision	Provide clinicians with ongoing supervision focusing on the innovation. Provide training for clinical supervisors who will supervise clinicians who provide the innovation
Provide local technical assistance	Develop and use a system to deliver technical assistance focused on implementation issues using local personnel
Provide ongoing consultation	Provide ongoing consultation with one or more experts in the strategies used to support implementing the innovation

Purposely reexamine the implementation	Monitor progress and adjust clinical practices and implementation strategies to continuously improve the quality of care
Recruit, designate, and train for leadership	Recruit, designate, and train leaders for the change effort
Remind clinicians	Develop reminder systems designed to help clinicians to recall information and/or prompt them to use the clinical innovation
Revise professional roles	Shift and revise roles among professionals who provide care, and redesign job characteristics
Shadow other experts	Provide ways for key individuals to directly observe experienced people engage with or use the targeted practice change/innovation
Stage implementation scale up	Phase implementation efforts by starting with small pilots or demonstration projects and gradually move to a system wide rollout
Start a dissemination organization	Identify or start a separate organization that is responsible for disseminating the clinical innovation. It could be a for-profit or non-profit organization
Tailor strategies	Tailor the implementation strategies to address barriers and leverage facilitators that were identified through earlier data collection
Use advisory boards and workgroups	Create and engage a formal group of multiple kinds of stakeholders to provide input and advice on implementation efforts and to elicit recommendations for improvements
Use an implementation advisor	Seek guidance from experts in implementation
Use capitated payments	Pay providers or care systems a set amount per patient/consumer for delivering clinical care
Use data experts	Involve, hire, and/or consult experts to inform management on the use of data generated by implementation efforts
Use data warehousing techniques	Integrate clinical records across facilities and organizations to facilitate implementation across systems
Use mass media	Use media to reach large numbers of people to spread the word about the clinical innovation
Use other payment schemes	Introduce payment approaches (in a catch-all category)
Use train-the-trainer strategies	Train designated clinicians or organizations to train others in the clinical innovation
Visit other sites	Visit sites where a similar implementation effort has been considered successful
Work with educational institutions	Encourage educational institutions to train clinicians in the innovation

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