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Incorporating Cognitive Behavioural Therapy into a Public Health Care System: Canada and England Compared

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A Comparative Health Reform Analysis

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Abstract

Since the second half of the 2000s, Canada and England have instituted differing reforms to address the inadequate provision and quality of mental health services in both nations. With growing evidence demonstrating the success and cost-effectiveness of psychotherapy, the English reform sought to expand the delivery of psychological services through the Improving Access to Psychological Therapies program (IAPT) focusing on cognitive behavioural therapy (CBT). In contrast, Canadian interventions at the federal level were centred on knowledge exchange and advocacy, primarily through the Mental Health Commission of Canada. While significant improvements were made during this period to increase CBT access in England, there continues to be an insufficient availability of psychological services to meet the growing need in Canada. While a national roll-out akin to the IAPT program in England is unlikely in Canada, similar reforms could be initiated at the provincial level of government. Indeed, several provincial governments have acknowledged the need for an expansion of CBT services and, over the last decade, some have tried to make CBT techniques more widely accessible. We review the case of the Bounce Back program developed in British Columbia (BC) to illustrate this potential in the Canadian context. Best practices indicate that care is needed beyond the provision of psychiatric services and pharmacotherapy alone, and the initial results of both the IAPT program and BC's Bounce Back program strongly suggest that it is possible to provide these cost-effective services in a public system.

Depuis la seconde moitié des années 2000, le Canada et l'Angleterre ont mis en place des réformes différentes pour tenter de remédier aux problèmes d'accès et de qualité des soins de santé mentale. Fondée sur des données probantes, la réforme anglaise a cherché à améliorer l'accès aux services de psychothérapie par le programme Improving Access to Psychological Therapies (IAPT) mettant l'accent sur la psychothérapie cognitivo-comportementale (PCC). En revanche, les interventions canadiennes au niveau fédéral ont été centrées sur le partage des connaissances et les programmes de sensibilisation, principalement par le biais de la Commission de la santé mentale du Canada. Ainsi, l'on observe une amélioration notable de l'accès à la PCC en Angleterre depuis la mise en œuvre de ces réformes, mais pas dans le contexte Canadien. Or, s'il est improbable d'envisager un programme fédéral du même type que l'IAPT au Canada, des réformes similaires pourraient néanmoins être initiées au niveau des provinces et territoires. En effet, plusieurs gouvernements provinciaux ont reconnu la nécessité d'une expansion des services de PCC. Nous examinons le cas du programme Bounce Back développé en Colombie-Britannique pour illustrer ce potentiel dans le contexte canadien. Les meilleures pratiques indiquent que la PCC est une composante nécessaire de l'éventail des services de santé mentale, et autant les résultats du programme IAPT que ceux du programme Bounce Back de la Colombie-Britannique suggèrent fortement qu'il est possible de fournir ces services de manière efficiente dans un système public.

Key Messages

- Despite a common recognition of limited mental health services, Canada and England implemented very different national strategies to address these concerns, with diverging results.
- While England's Improving Access to Psychological Therapies (IAPT) program appears to have significantly improved access to cognitive behavioural therapy (CBT) services in England, Canadian health services still fail to meet the need for psychological services such as CBT.
- Experience from the English reform can help to inform decisions to expand psychological services at the provincial level within Canada.

Messages-clés

- *Reconnaissant tous deux l'importance d'améliorer l'accès et la qualité des services de santé mentale, le Canada et l'Angleterre ont mis en œuvre des stratégies nationales très différentes pour répondre à ces préoccupations, avec des résultats divergents.*
- *Alors que le programme anglais IAPT semble avoir considérablement amélioré l'accès la psychothérapie cognitivo-comportementale, le système de santé canadien ne répond toujours pas globalement aux besoins en santé mentale.*
- *La réforme anglaise peut offrir des pistes pour l'amélioration de l'accès aux services de psychothérapie cognitivo-comportementale au niveau des provinces canadiennes.*

1 BRIEF DESCRIPTION OF THE REFORM

In this comparative health reform analysis (CHRA), we will contrast the Canadian and English attempts at reforming access to cognitive behavioural therapy (CBT), as part of their respective mental health strategies. Both countries acknowledged limitations in the provision and quality of mental health services in the second half of the 2000s, but the reforms stemming from this recognition were very different in scope and impact. In essence, the Canadian case is characterized by reforms consisting primarily of advisory reports from the federal Mental Health Commission of Canada (MHCC) to the provincial governments, while England’s Improving Access to Psychological Therapies program (IAPT) initiated a concerted effort to improve access to and standardize provision of CBT, among other initiatives. Although a similar nationwide reform in Canada through federal or intergovernmental action is improbable, it could very well be initiated at the provincial level of government. A number of provinces have in fact acknowledged the vast potential of CBT within mental health care, and many within the field have called for more widespread access to such services within Canada. British Columbia (BC) in particular has made efforts over the last decade to make cognitive behavioural techniques and therapies more widely accessible. We will use the case of the BC program (Bounce Back) that was implemented at the same time as (but independently of) both the IAPT program and the creation of the MHCC to illustrate the potential for collaboration between the federal level through the MHCC and provincial health authorities to enhance the provision of mental health services in Canada.

Thus, while the national reforms we describe in this CHRA are not technically similar, due in part to political differences in health care governance that have limited federal involvement in the mental health system in Canada, we argue that a comparative analysis is still fruitful here, to highlight the lessons that can be drawn by governments at both provincial and pan-Canadian levels. Furthermore, the Bounce Back example illustrates that it is within provinces’ and territories’ purview and capacity to consider such reforms, and within the role of the MHCC to facilitate progress.

2 HISTORY AND CONTEXT: MENTAL ILLNESS AND HEALTH CARE

2.1 CBT in the treatment of “common mental disorders”

Since the late 1970s, there has been a growing body of evidence in support of the effectiveness of CBT for the treatment of common mental disorders such as depression and anxiety (Duhoux *et al.* 2009; Gloaguen, Cottraux and Cucherat 1998). A 1998 meta-analysis on the effects of CBT in depressed patients found that CBT often was a viable alternative to pharmacological therapies and was also effective in conjunction with other treatments to prevent relapse (Gloaguen, Cottraux and Cucherat 1998). CBT focuses directly on altering

the thought and behavioural processes associated with the exaggerated fears and avoidance responses that help maintain anxiety, and this systematic “unlearning” process explains the stronger maintenance of treatment gains (Otto, Smits and Reese 2004). In addition, the use of CBT has been found to be an effective strategy for coping with difficulties associated with discontinuation of pharmacotherapy (Otto, Smits and Reese 2004).

2.2 Factors specific to the Canadian context

The Canada Health Act (CHA) of 1984 placed hospital and physician-provided services at the centre of the publicly-funded health care model, giving these forms of care a “privileged” position in Canada’s Medicare (Romanow and Marchildon 2003; Marchildon, Hadjistavropoulos and Koocher 2015). Consequently, public financing for mental health in Canadian provinces has tended to be largely allocated to services provided by psychiatrists and primary care physicians rather than psychologists or other mental health care providers.

As a result of this financing structure, primary care physicians have played a central role in the triaging process for publicly-funded specialist mental health services, consisting mainly of psychiatric services (Collins, Westra and Dozois 2004). According to Ohayon and Shapiro (2000), up to 83% of individuals with depression and/or anxiety had consulted a primary care physician at least once in the past 12 months; in addition, these individuals had also more frequently utilized primary care services compared to the general population over this period. Yet, despite the high presentation of mental disorders to primary care physicians, there appears to be significant under-detection of mental illness, in part because of the lack of primary care physician knowledge and skill in the diagnosis and treatment of mental disorders (Collins, Westra and Dozois 2004). The situation is further exacerbated by difficulties in contact and communication between primary care physicians and specialist mental health providers, and long wait times for referrals (Collins, Westra and Dozois 2004; Ohayon and Shapiro 2000).

In addition to delayed access to care, issues concerning quality of mental health care provided in Canada loom large and the availability of publicly-funded CBT for the treatment of mental health conditions is limited (if at all available) across the provinces and territories. Instead, pharmacotherapy has become the predominant form of treatment for “common mental disorders” such as anxiety and depression in Canada (Romanow and Marchildon 2003), perhaps as a result of the high proportion of mental health services being provided by general practitioners (Collins, Westra and Dozois 2004). Lack of knowledge and expertise in alternative psychotherapies, combined with poor access to psychiatric and specialist mental health services, may have put pressure on primary care physicians to treat mental disorders with the resources and training available to them (Collins *et al.* 2004).

Until 2007, very little action had been taken in Canada at the federal level to address access to and quality of mental health care services. In the previous year, the Standing Senate Committee on Social Affairs, Science, and Technology released its report *Out of the Shadows at Last*, the “most comprehensive study of mental health in Canada” to date

(Goldbloom and Bradley 2012, 221). A key finding of the report was the severe limitation of services available to Canadians seeking mental health care. For publicly-financed mental health care (offered primarily by psychiatrists and family physicians) long wait times and/or lack of training continued to act as barriers to services. Furthermore, outside of this scope of care many mental health services provided by other qualified health professionals were limited to those who could afford to pay out-of-pocket or who received coverage through employer plans. Although the committee argued that “no single treatment model should be allowed to dominate the policy horizon” (Kirby and Keon 2006, 47), it did recommend major mental health care reforms based on a recovery-oriented, person-centred, and predominantly community-based system.

Many provincial governments, notably British Columbia, echoed these sentiments. Given the growing research supporting CBT as an effective treatment for mild to moderate cases of anxiety and depression, making such therapies more readily available, especially through primary care, was seen as imperative. As a result, in early 2007 the BC Ministry of Health awarded \$6 million to the BC division of the Canadian Mental Health Association in order to develop community-based programs that would expand the provision of CBT in the province (CMHA 2014).

2.3 Factors specific to the English context

In 1999, the National Institute for Clinical Excellence (NICE; now National Institute for Health and Care Excellence, but still under the same acronym) was established to provide the English and Welsh National Health Services (NHS) with evidence on efficacy and cost-effectiveness of treatment and care (NICE 2015). In the mid-2000s it was recognized that many regions across the country were significantly underperforming in the delivery of psychological therapies (NICE 2008). With England facing many of the same issues as Canada (i.e., high burden of mental illness and social and economic associated costs), NICE embarked in 2004 on a systematic review of evidence on the effectiveness of a variety of depression and anxiety interventions (Clark 2011). This comprehensive assessment led to a wide range of clinical guidelines recommending and outlining the use of psychological therapies, in which CBT featured prominently in the treatment of anxiety and depression. However, the availability of CBT-related therapies (and trained professionals to deliver CBT services) at this stage was in limited supply within the English NHS.

In parallel, a knowledge transfer campaign was mounted by economists and clinical researchers from the Mental Health Policy Group of the London School of Economics claiming that an increase in access to psychological therapies would largely pay for itself, through both a decrease in illness-related public costs and an increase in revenues (Clark 2011; Marzillier and Hall 2009). This evidence was published in academic journals (Layard, Clark, and Knapp 2007) and in a research brief meant for public dissemination, titled *The Depression Report* commonly referred to as the “Layard Report” (LSE 2006). This report was widely circulated to knowledge users and the public, including being distributed in the

Sunday edition of a national newspaper (Clark 2011). By many accounts, the evidence in this report, along with the NICE recommendations were decisive factors in leading the government to commit to improving the availability of evidence-based mental health services (Clark 2011; Marzillier and Hall 2009).

3 GOALS OF THE REFORMS

Both jurisdictions stated general goals of improving the provision and quality of mental health services. However, the Canadian reform essentially consisted of information brokerage and advocacy (establishment of a Commission; development of a national strategy) whereas the English reform more directly addressed the delivery of services.

The Government of Canada established the Mental Health Commission of Canada (MHCC) in 2007 as a response to the recommendations made in the *Out of the Shadows at Last* report (Kirby and Keon 2006; Rosen and Goldbloom 2010). The MHCC identified three key strategic initiatives to address the challenges highlighted in the report: the development of a national mental health strategy, the institution of a 10-year anti-stigma campaign, and the creation of a national knowledge exchange centre (Kirby 2008). In keeping with these initiatives, the MHCC released Canada's first mental health strategy, *Changing Directions, Changing Lives* in 2012. Highlighted in the MHCC's national strategy was the critical need for increased access to evidence-based psychological therapies, as prioritized in countries such as the UK and Australia (MHCC 2012). When seeking services such as psychotherapy and clinical counselling, Canadians are simply waiting far too long for access to the limited availability of publicly-funded services despite the evidence substantiating both the clinical benefits and cost-effectiveness of such therapies in the treatment of mental illness (MHCC 2012). As such, the mental health strategy emphasized the urgent need for governments to address the increasingly "two-tier" (public/private) system in Canada with respect to access to psychological therapies (MHCC 2012).

The MHCC also identified a number of key priority areas for improvement in domains that are under the stewardship of the provincial governments. Most notably, to expand the role of primary care in addressing mental health needs, as well as to increase the availability and coordination of mental health services at the community level (MHCC 2012). Meanwhile, in 2008, the English Department of Health released an implementation plan for the IAPT program, the major objective of which was to assist primary care trusts (now clinical commissioning groups), which were the statutory bodies of the NHS responsible for planning and commissioning health care services, to implement NICE guidelines in diagnosing and treating depression and anxiety disorders. With this in mind, the English government announced an initial plan for targeting funding during the first three years, allocating a total of £173 million over the phased roll-out: an initial £33 million in the first year (2008/09), and an additional £70 million over each of the subsequent two years (Department of Health 2008). In addition to the primary aim of the program of improving

access to and quality of mental health services, Table 1 outlines three main performance targets and goals for the initial program roll-out.

Table 1: Performance goals for IAPT program (2008-2011)

GOALS	PERFORMANCE TARGET
PCT* coverage	At least 20 (of the 151) PCTs* implementing IAPT services in the first year (2008/09); increasing over the following two years
Skilled workforce	Training of up to 3,600 new psychological therapists by 2010/11 (60% CBT and 40% PWPs**)
Extending access to NICE-compliant services	900,000 more people accessing treatment At least 50% completing program and moving to recovery; 25,000 fewer on sick pay/benefits by 2010/11

* PCTs (primary care trusts)

** PWPs (psychological well-being practitioners)

4 FACTORS THAT INFLUENCED HOW AND WHY THE REFORMS CAME ONTO THE GOVERNMENTS' AGENDAS

In Canada, the issue came onto the federal government's agenda with the 2006 Senate report after a year of hearings in each province and territory as well as two online consultation processes yielding upward of 2,000 submissions. Given such stakeholder engagement, it was argued to present "the human face of mental illness and addiction" (Kirby and Keon 2006). The mode of reform chosen (a Commission, with the development of a national strategy for mental health, followed by knowledge transfer and brokerage strategies) reflects the intention of the federal government to stimulate provincial reforms without prescribing the exact mode of delivery.

In British Columbia, the issue entered the government's agenda due to a growing recognition in that province that mental health needs, particularly for anxiety and depression, were largely unmet (CMHA 2014). While not as directly as in the case of the federal reform, the BC program appears, at least in part, to have emerged out of the momentum created by the 2006 Senate report, particularly in its calls for community-based mental health reform.

In England, the issue entered the government's agenda due to both internal (out of the NICE assessment of mental health services) and external (from the public knowledge exchange campaign mounted by academics) pressure (LSE 2006). The technical nature of the NICE assessment and proposed solutions, buttressed by the economic argument of the academics, lent itself to a pragmatic, service-oriented reform, which was more readily implemented in the more centralized and integrated NHS.

5 HOW THE REFORMS WERE ACHIEVED

At the federal level in Canada, funding was allocated through Health Canada for the establishment of the Mental Health Commission of Canada, whose 10-year mandate (2007-2017) was to act as “a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues” (MHCC 2015). Supported by all federal political parties, the MHCC was also endorsed by all provincial (Québec excepted) and territorial governments. The MHCC produced the first national mental health strategy. This reform is situated rather low on the intervention ladder proposed by the Nuffield Council on Bioethics (2007), as it mainly consists of information provision (notably with the goal to reduce stigma) and enabling choice by engaging in knowledge exchange with governments, service providers, and community leaders on how best to improve the systems related to mental health care.

In contrast, in England, a policy intervention higher on the intervention ladder was chosen, namely to guide choice by changing the default policy. Public delivery of psychotherapies was wholly reformed. Pilots were conducted at two sites in Doncaster and Newham before the full roll-out of the reform (Clark *et al.* 2009) that focused on the delivery of CBT-related interventions per NICE guidelines (Layard, Clark and Knapp 2007). Both demonstration sites achieved strong recovery rates (55-56%) for people who received treatment of at least two sessions (n=1900). In both sites, the recovery rates amply exceeded what may be expected in the case of natural recovery or minimal intervention (Clark *et al.* 2009).

Initial roll-out (2008-2011). With promising results from the two demonstration sites, in October 2007 the government announced a nation-wide initiative to roll out the IAPT program across England following the NICE guidelines (Department of Health 2008). In this phase, goals (and their associated targets) centred on the training of providers to deliver the specific treatment outlined in the NICE guidelines (Department of Health 2008).

Continuing completion (2011-2015). Moving into the final years of program implementation, a number of additional targets were established alongside the roll-out of IAPT services for adults. In addition to increasing access to socially excluded communities, equitable access across the life course was also set as a goal (Jarman 2013). Given that many of the anxiety disorders observed in adults began in childhood and adolescence, the incorporation of an IAPT program targeted directly towards children and adolescents was deemed a priority (Department of Health 2011). At the other end of the life course, the elderly and their caregivers were also considered priority populations for the development of targeted programs (Jarman 2013).

In British Columbia an intervention located between those initiated by the federal government and the English NHS was chosen, primarily to enable choice. Adapted from the UK program Living Life to the Full, the CMHA launched Bounce Back: Reclaim your Health in 2008 to allow a wider range of individuals to “change their behaviour” by making guided self-help programs readily available through primary care practitioners (CMHA 2014). The

free program offers self-guided help through instructional materials that outline cognitive behavioural strategies for managing anxiety-related and depressive symptoms. These materials are coupled with telephone-guided therapy to help enforce learned CBT strategies (CMHA 2014). Over the span of a two-year three-phase roll-out, trained community coaches were established across the province's five health authorities.

6 OUTCOMES AND ECONOMIC EVALUATION OF THE REFORMS

6.1 Canada

Despite the intentions of the MHCC's national mental health strategy, criticism has been voiced about the effectiveness of mental health commissions in bringing about critical reform. Rosen and Goldbloom's (2010) evaluation of mental health commissions and advisory committees around the world classified the MHCC as a type II mental health commission, characterized by a broad and positive agenda targeted towards health care reform, but no capacity for implementation. While the MHCC was established with significant funding, its mandate was limited to research and advocacy. Indeed, the MHCC only serves in an advisory capacity, with decisional, financing and care administration capacity resting with provincial governments (Rosen and Goldbloom 2010). The challenge for these governments is that the current framework for public financing of health care set in place by the legacy of Medicare continues to pose a potential barrier to implementing integrated federal reforms to the mental health care system. However, throughout the Commission's first 10-year mandate, it initiated and supported a number of research projects aimed at assessing the impact of mental health-related programs in Canada such as At Home/Chez Soi and Psychological Health & Safety in the Workplace (MHCC 2014).

At the provincial level, initial outcomes of the Bounce Back program have been positive. Since the program's inception in 2008, over 120,000 Bounce Back DVDs were distributed to patients in BC, in addition to over 25,000 referrals made by primary care practitioners for telephone-guided counselling (CMHA 2014). In a sample of 6,891 patients in the Bounce Back program, pre- and post-therapy measures showed significant reductions in both depression severity and depression/anxiety symptoms in patients who completed the coaching program (CMHA 2014). A randomized control trial of the program is currently underway in BC and in select pilot sites in Alberta in order to formally evaluate both the effectiveness of Bounce Back in improving mental health outcomes and its cost-effectiveness (University of British Columbia 2014).

6.2 England

Outcomes for the first three years of the IAPT program implementation were very positive, either already achieving, or on target to achieve the goals originally pegged (Department

of Health 2011). Furthermore, there were strong indications that the program was not only beginning to have an impact on individuals' lives, but that it was also generating savings for the NHS through reduced reliance on welfare and increased tax contributions (Department of Health 2011). Midway through 2011, IAPT services had been established in 95% of PCTs (Clark 2011). A key issue observed was the wide variation in the number of therapists employed for IAPT services and thus, the number of patients who were assessed. It was estimated that only about 60% of the population actually had access to IAPT services (McHugh and Barlow 2010). In line with original targets, over 3,660 new high-intensity cognitive-behavioural therapists and PWPs completed training by the end of 2011. By the end of 2012, approximately 1.58 million people had entered treatment and 63,653 had moved off sick pay and benefits (Clark 2011). Recovery rates were reaching a respectable 44.4% compared to a target of 50% by full roll-out in 2015 (Department of Health 2011). However, there were also major challenges in the first three years, particularly with regard to ensuring equality in access and outcomes throughout the population (Clark 2013).

In addition, there has been some cost-benefit analysis of the program to-date. Mukuria and colleagues (2013) sought to determine the effectiveness of IAPT at Doncaster between 2007 and 2009 compared with two additional demonstration sites possessing similar population characteristics. Researchers found small differences between the improvements in patients receiving care at IAPT sites versus comparators, but found significant increases in utilization of NHS psychological therapies and decreases in the use of GP services at IAPT sites. Low response rates from patients may have impacted the representativeness of the sample and potentially underplayed important differences between the IAPT and comparator sites. The authors also found the IAPT site to be more expensive (not significantly) compared to comparator sites; however services still fell within the NICE threshold and considerable costs could have been associated with start-up and learning effects (Mukuria *et al.* 2013).

Radhakrishnan *et al.* (2013) provide a similar cost assessment of the IAPT program from 2009-10 in a larger sample of five primary care trusts in the East of England region. Results from the study indicated that the costs of current therapy in IAPT practices compare to previous estimates for CBT and support the cost models originally proposed for the program (Layard *et al.*, Clark and Knapp 2007).

Extrapolating from the economic assessments of the English program directly to the Canadian context is difficult, and care must be taken when assessing the generalizability of cost-benefit analyses from these independent studies. However, incorporating CBT into Medicare in Canada has the potential to bring major benefits both societally and in terms of burdening health care costs.

7 ANALYTIC COMPARISON

This comparative health reform analysis sought to highlight that the common recognition of limited mental health services in Canada and England was met with very different national strategies, and with diverging results. Indeed, we see that in the centralized English system, this recognition was met with direct action and the dissemination of CBT through the IAPT program. In contrast, the federal role in the Canadian context (through the MHCC) is limited to an advisory or knowledge broker one. Instead, it is at the provincial levels of government (as in the BC example) where direct action was taken to make CBT-related services more widely available. Nonetheless, Canadian services still struggle to meet the need for psychological therapies, whereas England appears to have made significant improvements. In this section, we draw from the Bounce Back experience as a potential model of reform in Canada wherein the federal role remains largely advisory, but with the initiation of reform at the provincial level, that role may become a more active one, facilitating the dissemination of provincial initiatives to other jurisdictions.

7.1 Linking the MHCC to provincial reform

While the two reforms at the national level alone may not be directly comparable, the Bounce Back program illustrates the potential for a more pan-Canadian approach to reforming the provision of mental health services through collaboration between the federal-level MHCC and provincial health authorities.

With the success of Bounce Back thus far, other provinces have shown interest in incorporating the model into their own mental health services, including Manitoba and Nova Scotia (CMHA 2014). The Nova Scotia Department of Health and Wellness, together with the MHCC, launched in 2013 a randomized control study of the Adult Mental Health Practice Support Program, which provides training and practical support for primary physicians in treating patients with mental illness, among a sample of patients with major depressive disorder (MHCC 2013). The study aims to determine the impact of the support program on patient outcomes, reducing stigma among care providers, and increasing comfort of primary care practitioners in delivering mental health care (MHCC 2013). Bounce Back will be incorporated into Nova Scotia's program as part of a set of self-management tools offered by physicians in the treatment arm (MHCC 2013). Not only will the study offer increased knowledge about the efficacy of the program, but it will also provide an opportunity to carry out economic analyses on its cost-effectiveness. Structured program evaluations such as these will hopefully encourage and promote program adoption across provinces and even nationally.

Given the MHCC's prioritization of mental health strategies that both expand the role of primary care in addressing mental health needs and increase the availability of mental health services at the community level (MHCC 2012), there is a demonstrable role for federal support in the roll-out of initiatives such as Bounce Back that target these priority areas.

However, timeliness is essential to meet the growing demand for psychological services like CBT in Canada, and provinces such as Manitoba and Ontario have already introduced the program in select regions (CMHA 2014; CMHA 2015). It remains to be seen whether the specific involvement of the MHCC with the BC program will translate to any expansion of CBT services in other provinces, particularly if ongoing evaluations demonstrate both improved therapeutic outcomes and cost-effectiveness of the program.

7.2 Considerations and additional research required

While there are a number of positive implications in incorporating CBT into the Canadian public health care model, the English experience highlights several considerations for the proper implementation and evaluation of reform in the Canadian context. A key factor in the speed and efficiency with which the IAPT program was implemented was the strong presence of the central government alongside the NHS. The current fragmentation of mental health care delivery at the federal and provincial/territorial levels in Canada serves as a potential (but hardly insurmountable) barrier to carrying out expansions similar to those taking place in England. While a parallel national roll-out akin to the English IAPT program may not be feasible, the opportunity nonetheless exists for provincial governments to act. Indeed, as BC's Bounce Back program illustrates, self-guided formats for the delivery of CBT techniques can make psychotherapies more widely accessible without substantial wait times. If CBT practitioners are to be made more readily available in meeting the demand for psychotherapy, an important consideration for reform will be assessing the impact of face-to-face therapy compared with telephone-administered CBT, particularly when treating more severe cases of mental illness (CMHA 2014).

7.3 Primary care reform and standards of care

Given the prominent role that family physicians play as a first-stop for those seeking mental health care, primary care serves as a valuable target for reform that focuses on collaborative care between primary and specialized services (Kates 2002; Marchildon, Hadjistavropoulos and Koocher 2015). Integrating mental health services more readily into primary care provides a number of benefits for the delivery of care, most notably increased access, earlier detection, and reaching out to marginalized populations that traditionally underuse mental health services (Kates 2002, 854).

However, with a number of primary health care reforms having been implemented across Canada over the last decade (Hutchison *et al.* 2011), consideration must be given to how these reforms may reshape the provision of CBT and standards of care. In the English case, expansion of CBT services was facilitated by the availability of NICE clinical guidelines outlining the use of CBT for the treatment of anxiety and depression, which were then incorporated into the IAPT program. Furthermore, formal accreditation procedures and standards exist for IAPT practitioners (as well as approved training programs) to ensure

consistency in the delivery of NICE-approved therapies, like CBT, across sites (NHS 2012). Ongoing monitoring of patient outcomes and the IAPT workforce aims to ensure that quality standards and program targets continue to be met (NHS 2012; NHS 2015).

Although a number of training programs for CBT are available across most provinces, a potential barrier to incorporating publicly-reimbursed CBT in Canada is the lack of a national standard, or standards, for CBT accreditation. A pan-Canadian standard for CBT credentialing may be essential in trying to expand the provision of publicly-reimbursed CBT beyond the existing framework and ensure a consistent level of service, particularly alongside primary care reforms. Indeed, developing a formal credentialing process for CBT practitioners has been determined a primary mandate of the Canadian Association of Cognitive and Behavioural Therapies (CACBT 2015). In addition to existing training programs, both the NICE guidelines on CBT and the structured outline of training dissemination from the IAPT program could prove extremely useful for provincial governments, particularly if efforts are made to more systematically incorporate CBT into the primary care setting.

Another issue is the generalizability of existing international research on cost-effectiveness to the Canadian context. For this, future research in Canada evaluating this economic impact will be essential. This research should also consider the costs of training, restructuring, and recruitment required in implementing CBT-related practices, a dimension often absent in current cost-effectiveness studies (Myhr and Payne 2006). Analysis from targeted programs, like the IAPT, may provide an opportunity to more accurately measure the benefits and impacts of incorporating CBT into the public health care model. As was done in England, implementing initial pilot sites in Canada may serve to evaluate the “competency” of CBT as a therapeutic model as well as the training and employment costs associated with meeting the demand for adequate numbers of CBT providers. Although not discussed here, an important distinction between the countries in terms of health care governance is in the different payment models for primary care. While primary care is largely capitated within England’s NHS, fee-for-service (FFS) remains the prominent payment model in Canada and FFS may act as a potential barrier to incorporating publicly-funded CBT in the Canadian context. The evaluation of existing programs, like Bounce Back, targeted at the provision of CBT-related strategies will be critical in determining cost-effectiveness in the Canadian context.

While individual provinces will remain the primary locus for reform, placing the discussion within the national context is important in illustrating how the framework for health care organization has had such a profound impact on the evolution of mental health services. Furthermore, the framework for publicly-reimbursed mental health services provides unique challenges in tackling issues of the provision of certain services, wait times, and availability of care. However, as the MHCC moves into a renewed ten-year mandate from the federal government in 2017, and with the pending release of the Mental Health Action Plan for Canada in 2016, new outlines for policy targets could increase collaboration between the commission and provinces, allowing for a more pan-Canadian approach to reform and an environment in which provincial governments can more readily draw policy lessons from

one another.

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