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Implementing Publicly Funded Psychotherapy Services: What Can Ontario Learn from England?

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A Comparative Health Reform Analysis

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Abstract

To address high rates of unmet need for mental health services in Ontario and England, both jurisdictions undertook the implementation of publicly funded psychotherapy programs with similar objectives, albeit in different time periods. Given the policy decision in Ontario to implement this approach, this paper aims to understand the lessons Ontario can learn from England in scaling up the Improving Access to Psychological Therapy program through an application of Kingdon's Multiple Streams Framework. The key policy difference between the two jurisdictions is that England has fully implemented its program nationwide, while Ontario is at the demonstration project phase. Therefore, a comparative health reform analysis (CHRA) is undertaken to trace the evolution of the mental health system reforms in relation to publicly funded psychotherapy services in the two jurisdictions. Across the problem, policy and politics streams, key concepts included indicator tracking, coalition building, and policy entrepreneurship. Key lessons Ontario can learn from the England story include further framing of the policy issue to rally public support and continuing to engage policy entrepreneurs in coalition building exercises. Research results may be useful for policymakers, provide groundwork for researchers, and encourage the public to play an active role in this important cause.

Pour répondre aux taux élevés de besoins non satisfaits en matière de services de santé mentale en Ontario et en Angleterre, les deux entités politiques ont entrepris de mettre en oeuvre des programmes de psychothérapie financés sur les fonds publics avec des objectifs similaires, bien qu'à des périodes différentes. Compte tenu de la décision de l'Ontario de mettre en œuvre cette approche, cet article vise à comprendre les leçons que l'Ontario peut tirer de l'Angleterre dans l'extension du programme d'amélioration de l'accès à la psychothérapie, en appliquant le cadre des courants multiples de Kingdon. La principale différence politique entre les deux juridictions est que l'Angleterre a entièrement mis en œuvre son programme à l'échelle nationale, tandis que l'Ontario en est à la phase du projet de démonstration. Par conséquent, une analyse comparative de la réforme de la santé (CHRA) est entreprise pour retracer l'évolution des réformes du système de santé mentale en relation avec les services de psychothérapie financés sur fonds publics dans les deux entités politiques. Parmi les courants du problème, des solutions politiques et des possibilités de réalisation politiques, les concepts clés comprennent le suivi des indicateurs, la création de coalitions et l'entreprenariat politique. Les principaux enseignements que l'Ontario peut tirer de l'histoire de l'Angleterre sont les suivants : mieux formuler la question politique afin de rallier le soutien du public et continuer à engager les entrepreneurs politiques dans des exercices de création de coalitions. Les résultats de la recherche peuvent être utiles aux décideurs politiques, fournir un travail de base aux chercheurs et encourager le public à jouer un rôle actif dans cette cause importante.

Key Messages

- The Multiple Streams Framework's examination of policy issues, presented solutions, and political factors provides an avenue of exploration useful for understanding how mental health policy operates in complex environments.
- Strong policy entrepreneurship played an instrumental role in the implementation of England's Improving Access to Psychological Therapy program.
- Lessons from the English context in relation to further framing of the policy issue to rally public support and continuing to engage policy entrepreneurs in coalition building exercises may aid Ontario in moving from their demonstration project to a province-wide program with ongoing funding.

Messages-clés

- *L'examen des questions politiques, des solutions présentées et des facteurs politiques dans le cadre de la théorie des courants multiples offre une voie d'exploration utile pour comprendre comment la politique de santé mentale fonctionne dans des environnements complexes.*
- *Un fort esprit d'entrepreneuriat politique a joué un rôle déterminant dans la mise en œuvre du programme « Improving Access to Psychological Therapy » (amélioration de l'accès aux thérapies psychologiques) en Angleterre.*
- *Les leçons tirées du contexte anglais en ce qui concerne le cadrage de la question politique pour rallier le soutien du public et la poursuite de l'engagement des entrepreneurs politiques dans des exercices de création de coalitions peuvent aider l'Ontario à passer de son projet de démonstration à un programme à l'échelle de la province avec un financement continu.*

1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

Annually, roughly 20% of Canadians experience a mental health problem (Smetanin et al., 2017). Further, half of all Canadians aged 40 and older will have, or have had, a mental health diagnosis (Smetanin et al., 2017), making it a leading cause of disability in Canada (Mental Health Commission of Canada, 2014). However, only about 20% of individuals who experience mental illness will access appropriate services (Urbanoski et al., 2017).

Mood and anxiety disorders account for nearly 80% of all mental illness diagnoses and psychotherapy is seen as a key treatment modality for these two diagnoses (Government of Canada, 2015; Coalition of Ontario Psychiatrists, 2018). Psychotherapy is a term used to describe a type of psychological treatment, which is centred on ‘talking work’ undertaken with a therapist (Centre for Addiction and Mental Health [CAMH], 2020a). Importantly, therapists providing such services are not necessarily physicians. In fact, most psychotherapies in Ontario are delivered by allied health professionals, including psychologists, social workers, occupational therapists, and nurses (Coalition of Ontario Psychiatrists, 2018). As such, many have argued that psychotherapy services are most effectively delivered by professionals outside of psychiatry for less complex mental health needs.

The objective of psychotherapy is to alleviate distress through discussing emotions, attitudes, and behaviours to promote healthy and adaptive methods of coping (CAMH, 2020). There are many different forms of psychotherapy, and some are supported by evidence of efficacy and cost-effectiveness in treating mental illnesses (Emmelkamp et al., 2014; Castelnovo et al., 2016). More specifically, a recent meta-analysis of randomized controlled trials concluded that depression-focused psychotherapies not only reduced depressive symptoms but also alleviated symptoms of anxiety compared to control conditions, which included waitlist, care-as-usual, and other inactive comparators (Weitz et al., 2018). Notably, there is a vast psychotherapy literature whereby conclusions are disputed with the main issues centred on the various modes of delivery and self-reported outcomes measures.

Nonetheless, there is strong support for psychotherapy within health professions as well as a social demand for such services in the general population. Importantly, professional groups in Ontario advocate that investing in structured psychotherapy can offer a significant return on investment, arguing that these investments not only address primary mental health concerns, but also mitigate secondary outcomes such as job loss and absenteeism from work (Coalition of Ontario Psychiatrists, 2018). However, it is noteworthy that these assessments rely on assumptions that can introduce bias, and as such, they reflect the position and advocacy interests of the organizing body rather than definitive empirical evidence.

In a general sense, psychotherapy has been performed throughout the ages, as individuals have employed psychological techniques to counsel one another (Reisman, 1991). Until modern methods of psychological treatment became the norm in the eighteenth century,

serious and persistent mental illnesses were viewed as demonic, requiring isolation and punishment (Rössler, 2016). At the end of the nineteenth century, Sigmund Freud established his “talking cure” in Austria (Myers, 2002). Between the 1920s and 1950s, the psychotherapy movement evolved with the introduction of behavioural therapies (Alessandri, Heiden, and Dunbar-Welter, 1995). While psychotherapy was predominantly within the scope of practise of psychiatrists, after World War II, integration of the practice occurred in relation to other health professions, especially clinical psychology (Buchanan, 2003). In the 1950s, Albert Ellis established rational emotive behaviour therapy, while Aaron Beck established cognitive therapy (Reisman, 1991). During the 1970s, both approaches merged to create what is now known as cognitive behavioural therapy (CBT) (Reisman, 1991). In summary, psychotherapy is a broad term encompassing various therapeutic approaches centred upon “talking work” with a therapist.

Prior to the reforms to be discussed in this paper, under universal health coverage in Ontario (i.e., the Ontario Health Insurance Plan [OHIP]), psychotherapy provided by non-physicians was not publicly funded, further exacerbating high rates of unmet needs for such services (Gratzer, 2020; Kurdyak et al., 2020). While community mental health and addiction services do offer psychotherapy, it is limited to specific populations and not tailored for mild-to-moderate needs. In Ontario, psychotherapy services are often covered to varying degrees under private workplace health insurance plans. Critically, there are shortages of psychiatrists in Ontario, and of the approximately 2,000 that are practising in the province, most are concentrated in large urban centres (CAMH, 2019; Kurdyak et al., 2014), contributing to long wait times for psychotherapy services and referral (Rudoler et al., 2019; Kurdyak et al., 2014; 2017).

To address unmet mental health service need, Ontario created a publicly funded psychotherapy program in February 2017, initially called the Increasing Access to Structured Psychotherapy (IASP) program and now known as the Ontario Structured Psychotherapy program (OSP) (Ontario Health, 2022) (please see Appendix for program details). This pilot program delivers publicly funded, evidence-informed psychotherapy treatment for adults with mild-to-moderate anxiety and/or depression via short-term individual or group sessions both in-person and virtually. Mild-to-moderate depression and anxiety were selected as target conditions because they are common mental disorders affecting a large proportion of those suffering from mental illness. These services are free to the end user, of which the intention is to increase accessibility. The typical referral pathways include self-referral (i.e., directly from the consumer) and via health care providers. The OSP program is modeled after the Improving Access to Psychological Therapies (IAPT), a program successfully implemented in England in 2008 (Ontario Health, 2021a). Please see the Appendix for program details alongside a description below. The objectives of the OSP program are to expand mental health services by providing CBT to thousands of the province’s residents and to train staff to provide evidence-informed psychotherapy (University of Toronto Psychiatry, 2020). All OSP program therapists must be members of regulated health or social professions (i.e., medicine, social work, nursing, psychology, occupational therapy) alongside

completing CBT training courses related to anxiety and depression accredited through a University of Toronto certificate program (please see Appendix for further details). Importantly, a major goal of this reform is to implement comprehensive programming to assist the province in meeting the mental health standards created by Health Quality Ontario (HQO) (Ontario Health, 2022). For the pilot phase, the Ontario Ministry of Health collaborated with four stand-alone, specialty mental health hospitals in the province to leverage their expertise and relationships with community partners to stand up the program. Each hospital was expected to work closely with primary care partners, community mental health and addictions services, family service organizations, and Indigenous organizations. Collaborative efforts enabled program delivery in settings that were close to home, and where people experiencing these conditions were likely to be identified. At all demonstration sites, the hospitals acted as network lead organizations and provided the intake, screening, assessment, and triaging functions. They also provided clinical expertise, including training and ongoing clinical consultation to therapists across their network regions. Furthermore, they were accountable for using measurement-based care tools and ensuring the network collected 86 common data elements and submitted them regularly to the CAMH Provincial System Support Program, of which the Ministry of Health provided funds to assist with the implementation and coordination efforts across sites. See Table 1 for brief overviews of each of the four mental health hospitals which participated in the OSP pilot phase.

Site	Overview
CAMH – Toronto	Staff delivered the CBT interventions in a variety of settings, with some targeted contracted partnerships for specific populations (centralized model)
Ontario Shores Centre for Mental Health Sciences – Greater Toronto Area (Ajax, Oshawa, Whitby, York Region)	Staff were embedded across a range of community partner settings and delivered the CBT interventions (centralized model)
The Royal Ottawa Hospital – Ottawa and Champlain regions	Staff contracted with partner sites to deliver the CBT interventions (distributed model)
Waypoint Centre for Mental Health Care – North Simcoe, Muskoka, Parry Sound and Dufferin, Caledon, Bolton regions	Staff contracted with partner sites to deliver the CBT interventions (distributed model)

Table 1: OSP Brief Site Overviews

England’s IAPT program provides effective psychological therapies delivered by accredited National Health Service (NHS) practitioners in relation to common mental health problems (i.e., anxiety, depression, stress) (NHS, 2022). Like the OSP, IAPT services are free to the end user. The principal goal of the IAPT program is to create programmatic

infrastructure, enabling primary care trusts (local health service/public health commissioning bodies) to implement the National Institute of Care and Excellence (NICE) guidelines for common mental conditions through a stepped-care model (NHS, 2019). The intention of the program is to improve access to evidence-informed talking therapies in the NHS by expanding the psychological therapy workforce and health services (Clark, 2018). Importantly, the program includes workforce planning to train mental health practitioners to provide the necessary services (Clark, 2018). In 2007, pilot sites were commenced in Newham and Doncaster, which will be described in subsequent sections.

The province of Ontario (Canada) and the country of England are comparable jurisdictions for health policy research for several reasons. Both jurisdictions are high-income per capita provinces/countries. Ontario and England are also both considered democratic provinces/countries with universal health coverage and similar political structures in relation to the Westminster cabinet parliamentary system (Organisation for Economic Cooperation and Development, 2023). Importantly, Ontario and England have health systems that are financed in similar ways. They are classified as operating predominantly tax-financed health systems. According to Böhm and colleagues (2013), England's health system type is a National Health Service (NHS). Here, regulation, financing, and provision of health services are all coordinated through the state, although some care is provided by private actors (e.g., general practice). According to the same taxonomy, Canada and thus Ontario's health system is classified as a National Health Insurance System (NHIS) whereby the provision of health services is private while the insurance financing is public (Böhm, et al., 2013). In both Ontario and England, there exists high rates of lost productivity, unmet need, and limited public coverage for mental health services (Bartram and Chodos, 2018). Importantly, a commonality across England's NHS and Ontario's NHIS is the use of primary care providers as gatekeepers to referred services.

The objective of this paper is to ask what can be learned from England in its implementation of the IAPT program for Ontario as it scales its efforts to increase access to psychotherapy through its OSP program. This research objective will be undertaken through a narrative policy analysis employing Kingdon's Multiple Streams Framework (MSF) (Kingdon, 1984). In this paper, we build on the work of Farmanara and colleagues (2016) in which they review and compare British Columbia's Bounce Back and the English IAPT programs. Their analysis highlights that while both jurisdictions recognized similar mental health system challenges, England achieved more substantial reform through centralized implementation and structured investment compared to Canada's federal role primarily remaining in an advisory capacity. Given Ontario's policy context, marked by provincial leadership, programmatic investment, and ambition closer to that of England, we employ the MSF to examine the dynamic interplay of political attention, problem framing, and policy entrepreneurship that has shaped psychotherapy program development in Ontario and England. Furthermore, this is the first paper to apply Kingdon's MSF to the implementation of psychotherapy programming and thus is a novel theoretical contribution to the literature.

2 HISTORY AND CONTEXT

2.1 Ontario

Medically necessary hospital and physician services in Ontario are free to patients at the point of service. Health services that fall outside of universal health coverage – for example, a large portion of pharmaceuticals, vision care, dental care and, importantly, mental health care – are predominantly paid by private insurance plans and out-of-pocket payments (Martin et al., 2018; Marchildon, 2014). Since the mid-1960s in Ontario, given the deinstitutionalization movement, there has been a strong emphasis placed on mental health care delivered in community-based settings as opposed to strictly in hospitals (Ontario Human Rights Commission, 2017). Here, while care within psychiatric hospitals have diminished in importance, community mental health services have increased (Mulvale, Abelson, and Goering, 2007). Although psychotherapy services provided by physicians are covered under OHIP, long wait times are the norm. Such a funding mechanism, in this case fee-for-service, results in family physicians being eligible to provide mental health services in primary care settings (Xierali et al., 2013). Despite this, there appears to be a lack of expertise and interest amongst family physicians regarding the diagnosis and treatment of mental illness (Collins et al., 2004). Furthermore, the time required for delivering a psychotherapy session, which is typically one hour, is not conducive to the average physician visit of 15 minutes. Limited access in conjunction with reduced quality of public mental health services in Ontario (and Canada as a whole) encourage many to seek services that are privately funded, leading to high out-of-pocket costs for those who can afford to pay (Ringel and Sturm, 2001).

2.2 England

The NHS delivers preventive medicine, hospital services, and primary care to all individuals designated as ordinarily resident in England. The Department of Health is the principal government agency responsible for setting policies related to the NHS, public health, and social care (Boyle, 2011). The following description of the English mental health system relates to how it existed in 2011 during its initial IAPT program rollout. Notably, many changes to health care organization have occurred in the last decade that are not reflected in this paper. For example, the NHS England became responsible for setting policies for the NHS, the Department of Health became the Department of Health and Social Care, as well as other major health system reorganization efforts. Like Ontario, there has been a transition from mental health care in hospitals to care provided in the community over the past several decades. The creation of the NHS in 1948 and the introduction of antipsychotics medications in the 1950s, in addition to numerous social and political factors, led to the closure of many psychiatric hospitals (Killaspy, 2006). Recently, mental health system reform in England has prioritized developing innovative care models and diversifying services to better meet citizens' needs (The King's Fund, 2014). Such developments have moved

towards approaches where patients are provided increasing levels of self-determination in relation to the mental health services they receive (The King’s Fund, 2014). Such emphasis on patient self-determination has been operationalized using self-referral to IAPT, which allows anyone to access psychological therapies directly through community clinics. England’s mental health challenges, including wait times, access, and service quality, mirror those of the Ontario context (Trusler et al., 2006; Turner et al., 2015).

3 THE POLICY-MAKING PROCESS

3.1 Multiple Streams Framework

John Kingdon’s Multiple Streams Framework (MSF) is a theory of agenda setting and policy change with its roots in American federal politics. The MSF is grounded in three streams: the problem stream, the policy stream, and the politics stream (Kingdon, 1984). In the problem stream, an issue is deemed to require attention. In the policy stream, an available solution to the issue is presented (Kingdon, 1984). Finally, in the politics stream, there lies motivation and opportunity to turn the proposed solution into policy (Kingdon, 1984). When the three streams converge, a policy window opens, and the issue can move onto the political agenda (Kingdon, 1984). Kingdon also highlights the importance of the policy entrepreneur, which refers to an individual who takes advantage of opportunities to influence policy outcomes (Kingdon, 1984). Importantly, the MSF provides foundational insight concerning policy entrepreneurs’ role by utilizing the streams to describe the space between an issue receiving attention and the uptake of an effective solution.

The MSF application will provide contextual and historical accounts of how the policy landscapes have developed in Ontario and England. By employing MSF in our comparative analysis, we can trace the timing and alignment of problem recognition, policy proposal development, and political receptivity, identifying approximately when policy windows opened. We can also compare how policy entrepreneurs in each jurisdiction navigated institutional constraints and leveraged windows of opportunity to advance the implementation of publicly funded psychotherapy programs. Finally, categorizing policy change into three distinct, yet interacting streams yields analytical benefits to assessing the influence of evidence, narrative, and political dynamics in driving mental health system reform.

3.2 Problem stream

The problem stream consists of policy topics requiring attention (Kingdon, 1984). There became widespread concern in England regarding the rising claims of state benefits, for example, the Incapacity Benefit and the Disability Living Allowance since their introduction by the Conservative Party in 1992 and 1995 (Burchardt, 1999; Boyle 2011). In December 2004, Richard Layard, an economist at the London School of Economics (LSE), led a seminar in the Prime Minister’s Strategy Unit entitled “Mental health: Britain’s biggest social

problem” (Holland, 2009). In this session, Layard outlined the negative effects of untreated mental illness on personal well-being and the related costs to the country in relation to welfare expenditures. He also asserted that mental illness can often prevent individuals from remaining employed or returning to work after being ill, in addition to the potentially damaging effects on families and the broader public. Importantly, Layard convincingly outlined the positive effects of improving access to evidence-informed psychological treatments for mental health conditions. By the mid-2000s, it was understood that many areas across England were underachieving in delivering psychological treatments (NICE, 2011). In 2006, a group of academics in the LSE Mental Health Policy Group became very active in the public discourse around this issue, making the economic case that psychological therapies would pay for themselves over time through uninterrupted employment (Clark, 2011). The combination of evidence via the NICE report and the pressure applied by respected academics lay the groundwork for reform measures to be implemented in the centralized NHS system. In 2006, a United Kingdom (UK) parliament publication applauded the increase in investment in psychological therapies by the NHS in recent years, but made clear that such services were not keeping up with demand (UK Parliament, 2006).

In Ontario, a 2006 report entitled “Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada” was released by the Standing Senate Committee on Social Affairs, Science and Technology (Kirby and Keon, 2006). This committee received submissions from Canadian citizens as well as through hearings conducted across the country. The group concluded that limited services, unacceptable wait times, and high out-of-pocket payments were common (Kirby and Keon, 2006). There has also been discontent regarding mental health services in mainstream media. For example, Erin Anderssen, a *Globe and Mail* staff writer, wrote articles in May and June of 2015 entitled “We have the evidence. . . Why aren’t we providing evidence-informed care” and “A matter of life and death” (Anderssen, 2015a; 2015b). Furthermore, an online investigative piece documented that many Ontarians face extremely long wait times, often exceeding six months to see a psychiatrist, outlining the substantial health and economic costs incurred by such delays (Taylor, 2015). Additionally, in 2018, a news article published province by province data showing that some Canadians experience year long waits times for publicly funded counselling, prompting experts to call for stronger federal leadership (Global News, 2018). In these pieces, various individuals in the news media have advocated for mental health system transformation in the form of publicly funded psychotherapy services.

Apart from the national narrative, it is essential to acknowledge the significant history specific to Ontario. The province has had a long and difficult history of attending to its populations’ mental health care issues. The progression towards deinstitutionalization beginning in the 1960s, spanning several decades, has increased both government and community attentiveness of the scope of these issues. However, the province has been slow to respond to this shift, leaving communities poorly resourced, and with mental health systems that are fragmented and arduous to navigate (Hartford et al., 2003; Mulvale et al., 2007). Moreover, programs lack capacity to serve those in need and patients lack access to

a broad range of mental health services, which may be partly due to insufficient funding levels. In 2013-2014, there was a \$3.5 billion investment from the Ministry of Health and Long-Term Care (MOHLTC) and the Ministry of Child and Youth Services (MCYS) alongside investments from education, justice, and housing (Brien et al., 2015). This investment constituted approximately 6.5% of Ontario's health budget. Nevertheless, this amount falls short of both the levels seen in some other countries and the recommended 9% target in *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (MHCC, 2012).

3.3 Policy stream

The policy stream consists of the presentation of available solutions to the issue at hand (Kingdon, 1984). In 2003, Layard met the clinical psychologist David Clark, and together they began to advocate for expanding psychological services with their key argument pertaining to cost-effectiveness (Clark, 2011). Layard's 2004 seminar to the Prime Minister's Strategy Unit was an important event. Here, his arguments were so convincing that the reform measure for expanding psychological therapies became a central commitment of the Labour Party campaign in the 2005 election (Holland, 2009). This evidence was transferred into a policy brief recommending the implementation of the NICE guidelines pertaining to the use of CBT to treat anxiety and depressive disorders (Layard, 2006). Notably, although Layard's report was framed as a UK-wide analysis, the IAPT program itself was only formally adopted within England's NHS. The Scotland, Wales, and Northern Ireland stories regarding publicly funded psychotherapy services are beyond the scope of the current comparative analysis. In the same year (2006), a UK parliament publication became the first government document to make the case for the IAPT program by providing a detailed scientific rationale (UK Parliament, 2006). We argue that these sequences of events constitute the beginning of a policy window opening.

In the Canadian context, in 2007, Health Canada funded the Mental Health Commission of Canada (MHCC) for a 10-year term to conduct research and pursue advocacy work related to mental health system reform. In June 2009, Dr. Annette Dufresne, a clinical psychologist, presented to the Select Committee on Mental Health and Addictions, discussing the importance of psychotherapy as a treatment for mental disorders. She outlined the range of interventions utilized in psychotherapy, the research supporting its use, and potential avenues available to increase access (Legislative Assembly of Ontario [LAO], 2009a). In September 2009, the Alliance of Psychotherapy Training Institutions presented to the same committee, providing persuasive information on the power of psychotherapy in the form of a publicly funded health service (LAO, 2009b). Later the same month, the Ontario Coalition of Mental Health Professionals also presented to the Select Committee on Mental Health and Addictions, furthering Dr. Dufresne's case by arguing that the development of practices and policies are needed to provide Ontarians with accessible psychotherapy services (LAO, 2009c). In August 2010, the Select Committee on Mental Health and Addictions

released its final report to educate politicians and advocate for organizational realignment, improved access to mental health services (including publicly funded psychotherapy), reformed physician remuneration models, and to increase the availability of affordable housing amongst other recommendations (LAO, 2010). In Ontario, Eric Hoskins (the then Ontario Health Minister) and Catherine Zahn (the President and CEO of CAMH), were actively involved in this health policy issue. Hoskins advocated heavily and educated politicians on the IASP program, as is evidenced through his presentations at the LAO in 2017 (LAO, 2017a; 2017b; 2017c). In 2016, Zahn pressed federal and provincial governments to commit to increasing access to structured psychotherapy and to categorize it as a medically necessary public service within “a reasonable time frame” (The Canadian Press, 2016). A year later, Zahn wrote a newspaper article advocating for increasing public funding for CBTs and other structured psychotherapies (Zahn, 2016).

In June 2011, the MHCC advocated for improved access to psychotherapy support groups through primary care providers and specific forms of psychotherapy through private sector counselling services (MacCourt, Wilson, and Tourigny-Rivard, 2011). In 2012 and 2013, the MHCC began advocating extensively for expanded psychotherapy services. This effort took the form of a review paper on collaborative care models for mental health services in primary care (Jeffries et al., 2013), an action guide on psychological health and safety for employers (Gilbert and Bilsker, 2012), and a national guideline for a service for family caregivers of adults with mental illness (MacCourt, 2013). Importantly, in 2012, the MHCC published “Changing directions, changing lives: The mental health strategy for Canada,” in which they outlined the need for improved access to psychological therapies (MHCC, 2012). The MHCC went on to publish “Advancing the mental health strategy for Canada: A framework for action (2017-2022)” whereby they called for increased access to evidence-informed psychotherapy services (MHCC, 2016) and “Options for improving access to counselling, psychotherapy and psychological services for mental health problems and illnesses” in which they discussed the feasibility of importing England’s IAPT to the Canadian context (Chodos, 2017). In 2014, the Mental Health and Addictions Leadership Advisory Council (MHALAC), a three-year advisory council, was created by the Government of Ontario to advise the Minister of Health and Long-Term Care, Eric Hoskins, how to implement Ontario’s Comprehensive Mental Health and Addictions Strategy. Shortly after, *The Globe and Mail* released an article by Erin Anderssen in May 2015, which discussed the increasing demand for mental health care services, the shortage of psychiatrists available to provide these services, and how there had been a “growing traction in Canada” to expand access to publicly funded psychotherapy (Anderssen, 2015a). In 2016, the MHALAC in its annual report advocated for an evidence-informed, publicly funded structured psychotherapy program (Ontario, 2016). Finally, in November 2017, Health Quality Ontario sent a report to the MOHLTC recommending that such a psychotherapy program delivered by non-physicians for anxiety and depression be implemented, noting that such a change would provide “clinical benefit and represents good value for money” (Teotonio, 2018). Additionally, two well-known academic psychiatrists at CAMH, Canada’s top research mental

health hospital, Drs. David Goldbloom and David Gratzler released an opinion piece in *The Globe and Mail* in December 2017, in which they discussed meeting with David Clark, one of the policy entrepreneurs of the IAPT program and both praised the cost-effectiveness of England’s IAPT program, and how Canada could utilize England’s program as “a roadmap for better access and [mental health access] outcomes” (Gratzler and Goldbloom, 2017).

3.4 Politics stream

In the politics stream, motivation and opportunity turn ideas into policy (Kingdon, 1984). Here, policymakers must pay attention to the issues at hand and be receptive to proposed solutions. In relation to the English context, Layard’s appointment to the House of Lords in 2000 was a key event, as he became prominent in Labour Party politics. It is critical to note that the Labour Party was in power in Britain from 1997 to 2010. A few years after Layard’s appointment, he worked closely with Clark to lobby government officials for health system reform measures related to expanding psychological therapies, and specifically CBT (Tyrer, 2014). In response to the lobbying by Layard and Clark alongside Layard’s 2006 report (described in the policy stream above), a white paper was published in January 2006, which outlined the government’s support for expanding psychological therapies and its plans to establish two demonstration sites at Newham and Doncaster (Department of Health, 2006). We argue that at this point in the England story, a policy window opened, providing fertile ground for program implementation.

Regarding the Ontario context, activity within the politics stream is ongoing. In April 2021, the Mental Health and Addictions Centre of Excellence at Ontario Health announced an expansion of the OSP program to approve six new health service providers to act as new lead organizations (Ontario Health, 2021b). These providers are the York Region Canadian Mental Health Association (Ontario Health region, Central), CarePoint Health (Ontario Health region, Central), St. Joseph’s Healthcare Hamilton (Ontario Health region, West), St. Joseph’s Health Care London (Ontario Health region, West), Health Sciences North (Ontario Health region, North), and St. Joseph’s Care Group, Thunder Bay (Ontario Health region, North). These new organizations joined the existing four lead organizations who worked with community-based service providers across various regions during the pilot phase of the program from 2017 to 2020. Governments generally acknowledge the importance of mental health services, but remain cautious when allocating potential public funds (collected via taxation), fearing moral hazard and potential over usage of coverage. Consequently, a barrier to expanding mental health service access centres upon fiscal concerns, acknowledging that such allocation of potential funds is inherently complex. In 2012, a Canadian Community Health Survey on mental health concluded that around 12% of adults with a common mental illness expressed a desire for therapy in the past year, with one third of the group (approximately 3% of the population) declaring that their needs went unmet (Statistics Canada, 2013). In 2018, approximately 5.3 million Canadians stated that they needed help for their mental health in the previous year (Moroz, Moroz, and D’Angelo,

2020). Of those needing help, 1.2 million stated that their needs were partially met (22%) and 1.1 million (21%) declared their needs were fully unmet (Moroz, Moroz, and D’Angelo, 2020). The need for counselling was the most likely to be unmet (34%) (Moroz, Moroz, and D’Angelo, 2020). Finally, a poll posing the question, “Should the Ontario government increase funding for mental health research and treatment?” yielded 88% of respondents to affirm the statement (I Side with Beta, 2020).

4 IMPLEMENTATION AND EVALUATION

4.1 IAPT program

An opportunity to implement the IAPT program arose when the Labour Government was re-elected in 2005, along with the continuing influence of Layard (a Labour government advisor). This instrumental event eventually led to the implementation of the IAPT program in 2007/2008. The Labour Government accepted the plan for the IAPT program in a conceptual sense in 2005. In 2007, pilot projects in Newham and Doncaster were conducted, with positive results (Clark et al., 2009). Later the same year, on World Mental Health Day (10 October), the Secretary of State for Health announced funding for the IAPT program, which consisted of £33 million in 2008-2009 (approximately 0.034% of the total NHS budget), an additional £70 million in 2009-2010 bringing the total to £103 million (approximately 0.103% of the NHS budget), and a further £70 million in 2010-2011, totaling £173 million (approximately 0.164% of the NHS budget) (Department of Health, 2008). By 2010-2011, the program had not yet fully expanded to cover the whole country, but was well on its way to achieving this aim (Department of Health, 2011). Notably, the IAPT program is designed to be open ended, but practical limitations exist such as the number of available therapists in certain regions of the country (NHS England, 2015). Regarding its funding mechanisms, the IAPT program is financed via NHS commissions and contracts as opposed to fee-for-service and capitation (NHS England, 2018).

The IAPT program has demonstrated encouraging results thus far. A Department of Health study evaluating the pilot projects at the two sites (Newham and Doncaster) reported recovery rates of 55-56% in clients who received a minimum of two treatment sessions (defined as moving from “case” to “non case” status on standardized measures of depression and anxiety) (Clark et al., 2009). Furthermore, according to an independent academic evaluation, IAPT services were accessible in 95% of primary care trusts (Clark, 2011). Moreover, by 2011, over 3,660 cognitive behavioural therapists had been trained to provide IAPT services (Clark, 2011). By 2012, roughly 1.58 million individuals entered treatment, while 63,653 individuals moved off sick leave or related welfare benefits (Clark, 2011). The program’s 2016-2017 comprehensive internal report demonstrated 1,385,664 new referrals, of which 965,379 entered treatment (NHS Digital, 2018). Furthermore, 87.5% of those that were treated waited less than six weeks to be seen, while 98.2% waited less than 18 weeks (NHS Digital, 2018). Finally, more than 500,000 individuals received IAPT services

yearly, with recent academic analyses illustrating that 44.4% of clients displayed recovery, while 64.5% demonstrated symptom improvement (Clark, 2018). Importantly, these recovery rates exceed the roughly 30% improvement often observed under waitlist or usual care conditions over comparable periods (Clark et al., 2009; Weitz et al., 2018). Such findings suggest that IAPT delivers superior clinical benefits compared to alternative or no treatment pathways, reinforcing its potential as a scalable public mental health intervention. While these data reflect a positive and compelling story of England’s IAPT program, we must be cognizant that various issues are likely to arise regarding program sustainability (e.g., workforce training/capacity, resource allocation, geographical disparities, and organizational restructuring). For example, frequent reorganization of commissioning bodies and subsequent shifts in accountability might undermine workforce stability, causing uneven training uptake and elevated staff turnover.

4.2 IASP/OSP program

In the Ontario context, there was no one major event that provided such a policy window for IASP/OSP program implementation. However, the groundwork for mental health system reform had been laid through recent efforts to destigmatize mental illness and elevate the topic in public discourse. In May 2017, the province announced \$73 million (approximately 0.051% of total program spending and 0.136% of health program spending) to be allocated over three years to create a publicly funded structured psychotherapy program (Government of Ontario, 2017). The move made Ontario the first and only province in Canada to commit to such a program.

Evidence from the Government of Ontario’s internal evaluation indicates that the IASP pilot achieved promising early gains in service access (Government of Ontario, 2019), a success likely reflecting its use of a non-physician-delivered psychotherapy model with proven effectiveness (Markowitz and Weissman, 2004). According to an internal government source, the program has demonstrated relatively high rates of recovery, reliable symptom improvement, and an overall decreased use of acute care services (Government of Ontario, 2019). Between October 2018 and December 2019, over 16,000 Ontarians enrolled in the IASP program (Government of Ontario, 2019). Between August 2018 to June 2019, 4,024 new clients enrolled in IASP, 8,409 IASP referrals were made, and there were 42 IASP clinicians in primary care settings (Government of Ontario, 2019). According to an internal CAMH report pertaining to recovery rates, between August 2018 and March 2019, 42% of clients moved from above to below caseness on anxiety/depression scores at treatment completion or program exit. Furthermore, in the same timeframe, 51% improved (by a set number of points) on such scores, irrespective of caseness at program exit or completion (Moore, 2019). These encouraging early outcomes not only demonstrate the program’s feasibility but also underscore the value of further investment and rigorous evaluation as Ontario considers province-wide scale up.

In June 2011, “Open Minds, Healthy Minds, Ontario’s Comprehensive Mental Health

and Addictions Strategy” was released, offering a comprehensive approach to transforming the provincial mental health system (Government of Ontario, 2011). This strategy included four goals: 1) improve the mental health and well-being for all Ontarians, 2) create healthy, resilient, and inclusive communities, 3) identify mental health and addictions problems early and intervene, and 4) provide timely, high-quality, integrated, and person-directed health care. In a policy analysis of this document, Bullock and Abelson (2019) discussed the presence of political leadership and concluded that the policy formulation and implementation stages of the strategy have improved the possibility of transforming Ontario’s mental health system. More recently, Ontario’s 2020 strategic plan for mental health and addictions explicitly discussed the importance of integrating mental health services into the primary care setting to create a more integrated and patient-centered system (Government of Ontario, 2020a).

5 ANALYTIC COMPARISON

The key policy difference between the two jurisdictions, which is the focus of this CHRA, is that England has fully implemented their publicly funded psychotherapy program nationwide, while Ontario is at the demonstration project phase. In England, approximately six years elapsed from the 2005 policy window opening to 2011 when IAPT services were accessible in 95% of primary care trusts (Clark, 2011). By contrast, Ontario’s IASP remained in its pilot phase only three years after the initial 2017 funding announcement (Government of Ontario, 2019). This gap of six years to essentially nationwide coverage in England compared to Ontario’s early phase rollout underscores how far Ontario trails England in widespread program implementation. Given this context, the two jurisdictions are at different phases of their respective program implementation stories. This section will outline several key concepts and discuss lessons that Ontario can learn from England regarding the elements that culminated in successful IAPT program implementation.

In relation to problem identification, the English government and academics were quick to recognize mental health policy problems as they arose. They did so through indicator tracking related to mental illness in the context of employment and welfare benefit claims. A key source that Layard relied on in his work was that of the Adult Psychiatric Morbidity Survey, which found that roughly one in five working age adults in England met criteria for a common mental disorder, underscoring the impact of incapacity related welfare claims (Meltzer et al., 2000). Similarly, Cribb, Karjalainen, and Waters (2022) showed that mental health conditions were the single largest diagnostic category among incapacity benefit and disability living allowance claimants, directly linking untreated mental illness to growing welfare caseloads. Importantly, there was a high degree of transparency regarding the issues that the health system was facing and there was a concerted effort to frame these problems in ways to appeal to the broader public. For example, the issue of mental illness was discussed not simply as an individual problem, but one that impacts economic growth

and the fabric of society. This type of national symbolism effectively persuades the public to take an engaged stance on the issues that are being discussed in the political arena. This type of engagement is possible when citizens believe that the government is acting in the best interest of the people. In relation to the Ontario context, such a surveying of indicators was also taking place in relation to feedback from Canadians, which was taken seriously through the work of the Standing Senate Committee on Social Affairs, Science and Technology. A lesson that Ontario can learn from England is to frame the discourse around the issue at hand in ways that rally public support and bring forth a positive unifying identity and message.

Regarding policy solutions to the problems presented, the English story demonstrates a prime example of coalition building, also referred to as “tipping” in Kingdon’s MSF, to create a strong policy community. The entrepreneurial actions of Clark, Layard and other academics at the LSE were strategic in a well-coordinated effort to soften or precondition the government and the public as they proposed policy solutions to the issue at hand through an effective knowledge translation campaign. These activities played well to improve the technical feasibility of the IAPT project proposal in the eyes of policy makers. In the Ontario context, the work of the presenters to the Select Committee on Mental Health and Addictions, the work of Hoskins, Zahn, and Bell, and the research and advocacy work of the MHCC were instrumental in bringing the policy issue of improved access to psychotherapy to the attention of the government. However, their case could have perhaps been stronger and more convincing if a less fragmented approach and a more coordinated plan were undertaken. For example, if a group of Canadian clinicians and/or researchers were to have lobbied the government, as Clark and Layard had, this in combination with the work of the MHCC may have produced a more pronounced effect on policymakers. Notably, unlike the UK’s centralized NHS, where strategic efforts in London naturally reverberate across the entire system, Ontario’s governance structure meant that key reports conducted in Ottawa (e.g., Mental Health Commission of Canada) could have been perceived as distant from Toronto’s health policy hubs. It could be that Ottawa based commissions struggle to convene the diverse regional health jurisdictions that comprise Ontario’s mosaic of local decision makers, negatively impacting widespread implementation of key programs.

Perhaps the most important lesson for Ontario is that of policy entrepreneurship. According to Kingdon (1984, p. 122-123), policy entrepreneurs are “advocates for proposals or for the prominence of an idea.” These individuals are defined by their willingness to invest resources in hopes of future returns. Such individuals know how to be effective through influencing how others understand policy problems and are skilled in formulating viable solutions (Weible and Cairney, 2018). According to Cairney (2018, p. 211), successful policy entrepreneurs use three strategies: 1) “tell a persuasive story to frame a policy problem,” 2) “make sure that their favoured solution is available before attention lurches to the problem” and, 3) “exploit a policy window during which policymakers have the willingness and ability to adopt their policy solution.” Clark and Layard were prime examples of individuals who took on the role of policy entrepreneur. Through their extensive engagement with

academics and government, they pushed the policy agenda forward in relation to expanding psychological therapies in a major way. Regarding the Ontario context, Eric Hoskins, Catherine Zahn, and Robert Bell (Deputy Minister of Health and Long-Term Care), seemed to have embodied the role of policy entrepreneur to certain degrees. Hoskins's presentations to the LAO in 2017 and Zahn's advocacy writing likely persuaded governments to commit to increasing access to structured psychotherapy. Robert Bell served as President and CEO of University Health Network (UHN) for nine years prior to serving as Deputy Minister of Health from 2014-2018, during the time the MHALAC was formed. Bell, a former orthopedic surgeon was an unexpected choice from the typical Deputy Minister as he had never worked in the bureaucracy before (Grant, 2014). However, many politicians such as Deborah Matthews, former Minister of Health, believed that Bell's long career as a frontline health care worker and leader could serve as a unique advantage in that he had insiders' knowledge to health care delivery (Grant, 2014). The MHALAC was made up of 20 members from diverse mental health sectors, one of which was Zahn, who was serving as CEO of CAMH. Bell and Zahn had been close colleagues from the time they had worked together at UHN, of which this positive working relationship contributed to the eventual adoption of the publicly funded psychotherapy program in the province.

As alluded to above, Clark and Layard took on the roles of policy entrepreneurs in profound ways. While there was some evidence of similar activity in the Ontario context through Hoskins, Zahn, and Bell's actions, this is a key difference in the implementation stories of each jurisdictions' respective publicly funded psychotherapy programs. Moving forward, policy entrepreneurs in the Ontario context could effectively communicate the problem at hand to the public through positive framing. Specifically, further policy entrepreneurship could aid in the creation and follow-through of a constructive plan to lobby the government. Lastly, there currently exists an opportunity to engage the public and the medical community to join forces in pushing for further psychotherapy program reform and development. Given how far Ontario has come in its journey to date, it is our hope that the push continues.

A closer look at the six-year gap to nationwide IAPT coverage in England compared to Ontario's three-year demonstration pilot highlights the need for more deliberate coupling of problem, policy, and politics streams in Ontario. Drawing on implementation science, future research should map system level enablers and barriers, such as regional capacity, funding mechanisms, and workforce capacity and readiness, using frameworks like the Consolidated Framework for Implementation Research (Damschroder et al., 2009). Applied health policy researchers should consider establishing performance dashboards to track key metrics and form community advisory groups to sustain engagement and resource commitment beyond the demonstration phase (Cargo and Mercer, 2008). To strengthen the MSF's descriptive capacity, integrating insights from other policy change theories, for example the Advocacy Coalition Framework, could illuminate how stakeholder beliefs and alliances evolve during program rollout (Sabatier and Jenkins Smith, 1993). Politically, Ontario's current openness to mental health reform presents a policy window that can be capitalized upon by crafting

clear cost benefit narratives tied to broader system priorities (Kingdon, 1984). Finally, a mixed methods evaluation, combining fidelity monitoring, economic analyses, and stakeholder interviews, would help generate key learnings for both scholars and decision makers planning the next phase of provincial implementation in Ontario.

This paper has outlined the implementation journeys of Ontario's IASP/OSP and England's IAPT programs through an application of the MSF (Kingdon, 1984). The major implication is if the above lessons discussed are to be applied, this could potentially aid Ontario in scaling up its demonstration project to a sustainable provincial program. Furthermore, given the decentralized nature of Canadian health systems, learnings from the Ontario context may also be relevant to other Canadian jurisdictions interested in developing their own publicly funded psychotherapy programs. Our analysis extends the work of Farmanara and colleagues (2016) in their comparison of British Columbia's Bounce Back initiative with England's IAPT program, which found that England's centralized funding model and structured investments drove more comprehensive mental health system change, whereas BC's primarily advisory, decentralized approach achieved lesser gains. By bringing Ontario into this comparative study, where provincial policy entrepreneurs played a role in securing demonstration project program funding, our MSF analysis provides insights into how shifts in political attention, problem framing, and institutional capacity interact. In doing so, our paper contributes to the wider mental health policy literature by unpacking several mechanisms through which structured investment and policy entrepreneurship set the stage for publicly funded psychotherapy service reforms across health systems. Another strength of this study is that it is the first paper to apply the MSF to the implementation of psychotherapy programming, and thus this is a novel contribution to the scholarly literature. Importantly, unlike other policy frameworks, the MSF offers a flexible and dynamic approach in explaining policy windows, allows for complexity and nuance, and highlights the critically important role of policy entrepreneurs. A limitation of this work is the sole use of MSF as opposed to its potential to be used in conjunction with other frameworks (e.g., Punctuated Equilibrium Theory, Advocacy Coalition Framework, 3-I Framework). The research results presented in this study may be informative to policymakers, provide a foundation for future health policy research, and encourage the public to join forces in this important mission to improve population mental health.

6 REFERENCES

- Alessandri M, Heiden KA, Dunbar-Welter M. 1995. *Introduction to clinical psychology*. Boston, MA: Springer.
- Anderssen E. 2015a. The case for publicly funded therapy. *The Globe and Mail*, May 22. <https://www.theglobeandmail.com/life/the-case-for-publicly-funded-therapy/article24567332/>.
- Anderssen E. 2015b. A matter of life and death. *The Globe and Mail*, June 4. <https://www.theglobeandmail.com/life/a-matter-of-life-and-death/article24567332/>.

- [//search-proquest-com.myaccess.library.utoronto.ca/canadiannews/docview/2122289685/fulltextPDF/417B5C728A344A5EPQ/1?accountid=14771](https://search-proquest-com.myaccess.library.utoronto.ca/canadiannews/docview/2122289685/fulltextPDF/417B5C728A344A5EPQ/1?accountid=14771).
- Bartram M, Chodos H. 2018. Expanding access to psychotherapy: mapping lessons learned from Australia and the United Kingdom to the Canadian context. Ottawa, ON: Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/sites/default/files/2018-08/Expanding_Access_to_Psychotherapy_2018.pdf.
- Böhm K, Schmid A, Götze R, Landwehr C, Rothgang H. 2013. Five types of OECD healthcare systems: empirical results of a deductive classification. *Health Policy* 113(3), 258-269. <https://doi.org/10.1016/j.healthpol.2013.09.003>.
- Boyle, S. 2011. United Kingdom (England): health system review. London, UK: European Observatory on Health Systems and Policies.
- Buchanan RD. 2003. Legislative warriors: American psychiatrists, psychologists, and competing claims over psychotherapy in the 1950s. *Journal of the History of the Behavioral Sciences* 39(3), 225-249. <https://doi.org/10.1002/jhbs.10113>.
- Bullock, HL, Abelson J. 2019. A fresh approach to reform? A policy analysis of the development and implementation of Ontario's mental health and addictions strategy. *Healthcare Policy* 14(3), 29-42. <https://doi.org/10.12927/hcpol.2019.25794>.
- Burchardt T. 1999. The evolution of disability benefits in the UK: re-weighing the basket. LSE STICERD Research Paper No. CASE026. http://eprints.lse.ac.uk/6490/1/The_Evolution_of_Disability_Benefits_in_the_UK_Re-weighting_the_basket.pdf.
- Cairney P. 2018. Three habits of successful policy entrepreneurs. *Policy & Politics* 46(2), 199-215. <https://doi.org/10.1332/030557318X15230056771696>.
- Cargo M, Mercer SL. 2008. The value and challenges of participatory research: strengthening its practice. *Annual Review of Public Health*, 29(1), 325-50.
- Canadian Press 2016. Feds urged to make mental health top priority in health accords negotiations. *CityNews*, October 27. <https://www.citynews1130.com/2016/10/27/feds-urged-to-make-mental-health-top-priority-in-health-accord-negotiations/>.
- Castelnuovo G, Pietrabissa G, Cattivelli R, Manzoni GM, Molinari E. 2016. Not only clinical efficacy in psychological treatments: clinical psychology must promote cost-benefit, cost-effectiveness, and cost-utility analysis. *Frontiers in Psychology* 7, 563. <https://doi.org/10.3389/fpsyg.2016.00563>.
- Centre for Addiction and Mental Health. 2019. Mental illness and addiction: facts and statistics. <https://www.camh.ca/en/driving-change/the-crisis-is-real/mental-health-statistics>.
- Centre for Addiction and Mental Health. 2020a. Ontario structured psychotherapy (OSP) program. <https://www.camh.ca/en/patients-and-families/programs-and-services/ontario-structured-psychotherapy-osp-program>.
- Centre for Addiction and Mental Health. 2020b. What is psychotherapy? <https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/psychotherapy>.
- Chodos H. 2017. Options for improving access to counselling, psychotherapy and psychological services for mental health problems and illnesses. Ottawa, ON: Health Canada.

- https://www.mentalhealthcommission.ca/sites/default/files/2017-07/Options_for_improving_access_to_counselling_psychotherapy_and_psychological_services_eng.pdf.
- Clark DM. 2011. Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry* 23(4), 318-327. <https://doi.org/10.3109/09540261.2011.606803>.
- Clark DM. 2018. Realizing the mass public benefit of evidence-informed psychological therapies: The IAPT program. *Annual Review of Clinical Psychology* 14. <https://doi.org/10.1146/annurev-clinpsy-050817-084833>.
- Clark DM, Layard R, Smithies R, Richards DA, Suckling R, Wright B. 2009. Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy* 47(11), 910-20. <https://doi.org/10.1016/j.brat.2009.07.010>.
- Coalition of Ontario Psychiatrists. 2018. Talk and transform: recommendations for moving forward with a structured psychotherapy program in Ontario. [https://www.eopa.ca/sites/default/uploads/files/Talk%20and%20Transformation_Recommendations%20or%20a%20structured%20psychotherapy%20program%20in%20Ontario\(1\).pdf](https://www.eopa.ca/sites/default/uploads/files/Talk%20and%20Transformation_Recommendations%20or%20a%20structured%20psychotherapy%20program%20in%20Ontario(1).pdf).
- Collins KA, Westra HA, Dozois DJ, Burns DD. 2004. Gaps in accessing treatment for anxiety and depression: challenges for the delivery of care. *Clinical Psychology Review* 24(5), 583-616. <https://doi.org/10.1016/j.cpr.2004.06.001>.
- Cribb J, Karjalainen H, Waters T. 2022. Living standards of working-age disability benefits recipients in the UK (IFS Working Paper 22/24). Institute for Fiscal Studies. <https://doi.org/10.1920/wp.ifs.2022.2422>.
- Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. 2009. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science* 4(1), 50. <https://doi.org/10.1186/1748-5908-4-50>.
- Department of Health. 2011. Impact assessment of the expansion of talking therapies services as set out in the Mental Health Strategy. https://assets.publishing.service.gov.uk/media/5a7c68a440f0b62aff6c1767/dh_123997.pdf.
- Department of Health. 2008. Improving access to psychological therapies implementation plan: national guidelines for regional delivery. <https://www.mhinnovation.net/sites/default/files/content/document/IAPT-Implementation-Plan.pdf>.
- Department of Health. 2006. Our health, our care, our say: a new direction for community services. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf.
- Emmelkamp PM, David D, Beckers T, Muris P, Cuijpers P, Lutz W, et al. 2014. Advancing psychotherapy and evidence-informed psychological interventions. *International Journal of Methods in Psychiatric Research* 23(S1), 58-91. <https://doi.org/10.1002/mpr.1411>.
- Farmanara N, Marchildon GP, Quesnel-Vallée. 2016. Incorporating cognitive behavioural

- therapy into a public health care system: Canada and England compared. *Health Reform Observer – Observatoire des Réformes de Santé* 4(2). <https://mulpress.mcmaster.ca/hro-ors/article/view/2661>.
- Gilbert M, Bilsker D. 2012. Psychological health and safety: an action guide for employers. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/Workforce_Employers_Guide_ENG_1.pdf.
- Global News. 2018. There are stark disparities in access to mental health services across Canada. <https://globalnews.ca/news/5956330/mental-health-services-access-canada/#:~:text=The%20results%20show%20significant%20disparities,or%20no%20time%20at%20all>.
- Government of Canada. 2015. Mood and anxiety disorders in Canada: fast facts from the 2014 survey on living with chronic diseases in Canada. <https://www.canada.ca/en/public-health/services/publications/diseases-conditions/mood-anxiety-disorders-canada.html>.
- Government of Ontario. 2011. Ontario, open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy. https://www.opsba.org/wp-content/uploads/2021/02/Ontario_OpenMindsHealthyMinds_EN.pdf.
- Government of Ontario. 2016. Moving forward: better mental health means better health. https://www.health.gov.on.ca/en/common/ministry/publications/reports/bmhmbh_2016/moving_forward_2016.pdf.
- Government of Ontario. 2017. Ontario improving mental health services for people across the province. <https://news.ontario.ca/en/release/46430/ontario-improving-mental-health-services-for-people-across-the-province>.
- Government of Ontario. 2019. Chapter 3: ten recommendations to improve health care. <https://www.ontario.ca/document/healthy-ontario-building-sustainable-health-care-system/chapter-3-ten-recommendations-improve-health-care>.
- Government of Ontario. 2020a. Roadmap to wellness: a plan to build Ontario's mental health and addictions system. <https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system>.
- Grant, K. 2014. Former surgeon to shake up Ontario's Health Ministry. *The Globe and Mail*. <https://www.theglobeandmail.com/news/national/former-surgeon-to-shake-up-ontarios-health-ministry/article17715543/>.
- Gratzer D. 2020. Improving access to evidence-informed mental health care. *Canadian Medical Association Journal* 192(13), E324. <https://doi.org/10.1503/cmaj.200156>.
- Gratzer G, Goldbloom D. 2017. For better mental-health care in Canada, look to Britain. *The Globe and Mail*. <https://www.theglobeandmail.com/opinion/for-better-mental-health-care-in-canada-look-to-britain/article37358415/>.
- Holland R. 2009. Improving access to psychological therapies: the intention. *London Journal of Primary Care* 2(1), 50-51. <https://osptraining.ca/moodle/>.
- IASP CBT Training Program. 2020. <https://canada.isidewith.com/poll/287142613>.

- I Side with Beta. 2020. Should the government increase funding for mental health research and treatment? <https://canada.isidewith.com/poll/287142613/9330440#pie>.
- Jeffries V, Slaunwhite A, Wallace N, Menear M, Arndt J, Dotchin J, et al. 2013. Collaborative care for mental health and substance use issues in primary health care. Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/PrimaryCare_Overview_Reviews_Narrative_Summaries_ENG_0.pdf.
- Killaspay H. 2006. From the asylum to community care: learning from experience. *British Medical Bulletin* 79(1), 245-258. <https://doi.org/10.1093/bmb/ldl017>.
- Kingdon JW. 1984. *Agendas, alternatives, and public policies*. New York, NY: Harper-Collins.
- King's Fund. 2014. Service transformation: lessons from mental health. https://assets.kingsfund.org.uk/f/256914/x/88feefd75c/service_transformation_february_2014.pdf.
- Kirby JL, Keon WJ. 2006. Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada. https://www.mentalhealthcommission.ca/sites/default/files/out_of_the_shadows_at_last_-_full_0_0.pdf.
- Kurdyak P, Stukel TA, Goldbloom D, Kopp A, Zagorski BM, Mulsant BH. 2014. Universal coverage without universal access: a study of psychiatrist supply and practice patterns in Ontario. *Open Medicine* 8(3), e87. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4242254/pdf/OpenMed-08-87.pdf>.
- Kurdyak P, Zaheer J, Carvalho A, Lebenbaum M, Wilton AS, Fefergrad M, et al. 2020. Physician-based availability of psychotherapy in Ontario: a population-based retrospective cohort study. *CMAJ Open* 8(1), E105-E115. <https://doi.org/10.9778/cmajo.20190094>.
- Kurdyak P, Zaheer J, Cheng J, Rudoler D, Mulsant BH. 2017. Changes in characteristics and practice patterns of Ontario psychiatrists: implications for access to psychiatrists. *Canadian Journal of Psychiatry* 62(1), 40-47. <https://doi.org/10.1177/0706743716661325>.
- Layard R. 2006. The depression report: a new deal for depression and anxiety disorders (No. 15). Centre for Economic Performance, LSE. <https://cep.lse.ac.uk/pubs/download/special/depressionreport.pdf>.
- Legislative Assembly of Ontario. 2009a. Committee transcript 2009-Jun-15. <https://www.ola.org/en/legislative-business/committees/mental-health-addictions/parliament-39/transcripts/committee-transcript-2009-jun-15>.
- Legislative Assembly of Ontario. 2009b. Committee transcript 2009-Sep-08. <https://www.ola.org/en/legislative-business/committees/mental-health-addictions/parliament-39/transcripts/committee-transcript-2009-sep-08>.
- Legislative Assembly of Ontario. 2009c. Committee transcript 2009-Sep-30. <https://www.ola.org/en/legislative-business/committees/mental-health-addictions/parliament-39/transcripts/committee-transcript-2009-sep-30>.

- Legislative Assembly of Ontario. 2010. Navigating the journey to wellness: The comprehensive mental health and addictions action plan for Ontarians. <https://www.ola.org/sites/default/files/node-files/committee/report/pdf/2010/2010-08/report-2-EN-Select%20Report%20ENG.pdf>.
- Legislative Assembly of Ontario. 2017a. Committee transcript 2017-Mar-07. <https://www.ola.org/en/legislative-business/committees/government-agencies/parliament-41/transcripts/committee-transcript-2017-mar-07>.
- Legislative Assembly of Ontario. 2017b. Committee transcript 2017-Sep-13. <https://www.ola.org/en/legislative-business/house-documents/parliament-41/session-2/2017-09-13/hansard>.
- Legislative Assembly of Ontario. 2017c. Committee transcript 2017-Nov-20. <https://www.ola.org/en/legislative-business/house-documents/parliament-41/session-2/2017-11-20/hansard>.
- MacCourt P. 2013. National guidelines for a comprehensive service system to support family caregivers of adults with mental health problems and illness. Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/Caregiving_MHCC_Family_Caregivers_Guidelines_ENG_0.pdf.
- MacCourt P, Wilson K, Tourigny-Rivard MF. 2013. Guidelines for comprehensive mental health services for older adults in Canada. Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2017-09/mhcc_seniors_guidelines_0.pdf.
- Marchildon GP. 2014. The three dimension of universal Medicare in Canada. *Canadian Public Administration* 57(3), 362-382. <https://doi.org/10.1111/capa.12083>.
- Markowitz JC, Weissman MM. 2004. Interpersonal psychotherapy: principles and applications. *World Psychiatry* 3(3), 136. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414693/pdf/wpa030136.pdf>.
- Martin D, Miller AP, Quesnel-Vallée A, Caron NR, Vissandjé B, Marchildon GP. 2018. Canada's universal health care system: achieving its potential. *The Lancet* 391(10131), 1718-1735. [https://doi.org/10.1016/S0140-6736\(18\)30181-8](https://doi.org/10.1016/S0140-6736(18)30181-8).
- Meltzer H, Gill B, Petticrew M, Hinds K. 2000. Psychiatric morbidity among adults living in private households, 2000: Technical report. The Stationery Office. <https://doc.ukdataservice.ac.uk/doc/4653/mrdoc/pdf/4653userguide1.pdf>.
- Mental Health Commission of Canada. 2012. Changing directions, changing lives: the mental health strategy for Canada. https://mentalhealthcommission.ca/wp-content/uploads/drupal/MHStrategy_CaseForInvestment_ENG_0_1.pdf.
- Mental Health Commission of Canada. 2014. Why investing in mental health will contribute to Canada's economic prosperity and to the sustainability of our health care system. <https://www.mentalhealthcommission.ca/English/media/3104>.
- Mental Health Commission of Canada. 2016. Advancing the mental health strategy for Canada: a framework for action (2017-2022). https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2016-08/advancing_the_mental_health_strategy_for

- _canada_a_framework_for_action.pdf.
- Moore R. 2019. Ontario structured psychotherapy [PowerPoint slides]. <https://www.cmho.org/images/conference-2019/Presentations/Moore%20-%20OSP%20Overview.pdf>.
- Moroz N, Moroz I, D'Angelo MS. 2020. Mental health services in Canada: barriers and cost-effective solutions to increase access. *Healthcare Management Forum* 33(6), 282-287).
- Mulvale G, Abelson J, Goering P. 2007. Mental health service delivery in Ontario, Canada: how do policy legacies shape prospects for reform? *Health Economics, Policy and Law* 2(4), 363-389. <https://doi.org/10.1017/S1744133107004318>.
- Myers B. 2002. History of psychotherapy. *BBC News*. <https://www.bbc.co.uk/programmes/p03kc7x1>.
- National Health Service. 2018. The improving access to psychological therapies manual. <https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/>.
- National Health Service. 2022. NHS talking therapies. <https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies/>.
- National Health Service Digital. 2018. Psychological therapies: annual report on the use of IAPT services England, further analyses on 2016-17. <https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2016-17-further-analyses>.
- National Health Service England. 2015. Adult IAPT workforce census report (April 2015). <https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/09/adult-iapt-workforce-census-report-15.pdf>.
- National Health Service England. 2018. Paying for quality and outcomes: IAPT case studies. <https://www.england.nhs.uk/wp-content/uploads/2018/04/iapt-payment-case-study.pdf>.
- National Institute for Health and Care Excellence. 2011. Common mental health problems: identification and pathways to care. <https://www.nice.org.uk/guidance/cg123/resources/common-mental-health-problems-identification-and-pathways-to-care-pdf-35109448223173>.
- National Institute for Health and Care Excellence. 2015. Who we are. <https://www.nice.org.uk/about/who-we-are>.
- Ontario Health. 2022. Mental health and addictions programs and resources. <https://www.ontariohealth.ca/clinical/mental-health-addictions/clinical-resources>.
- Ontario Health. 2021a. Update on the Ontario structured psychotherapy program. <https://www.ontariohealth.ca/news/expansion-structured-psychotherapy>.
- Ontario Health. 2021b. Ontario Health welcomes expansion of Ontario structured psychotherapy program. <https://www.ontariohealth.ca/about-us/news/news-release/ontario-health-welcomes-expansion-ontario-structured-psychotherapy>.

- Ontario Human Rights Commission. 2017. Policy on preventing discrimination based on mental health disabilities and addictions: appendix a: historical context. <https://www3.ohrc.on.ca/en/policy-preventing-discrimination-based-mental-health-disabilities-and-addictions/appendix>.
- Organisation for Economic Co-operation and Development. 2023. Health at a glance 2023: OECD indicators. OECD Publishing. https://www.oecd.org/en/publications/health-at-a-glance-2023_7a7afb35-en.html.
- Reisman JM. 1991. *A history of clinical psychology*. Oxfordshire, UK: Taylor & Francis
- Ringel JS, Sturm R. 2001. Financial burden and out-of-pocket expenditures for mental health across different socioeconomic groups: results from healthcare for communities. <https://www.rand.org/pubs/reprints/RP1331.html>.
- Rössler W. 2016. The stigma of mental disorders. *EMBO Reports* 17(9), 1250-1253. <https://doi.org/10.15252/embr.201643041>.
- The Royal. 2020. Short term talk therapy (IASP program). <https://www.theroyal.ca/patient-care-information/clinics-services-programs/short-term-talk-therapy-iasp-program>.
- Rudoler D, de Oliveira C, Zaheer J, Kurdyak P. 2019. Closed for business? Using a mixture of models to explore the supply of psychiatric care for new patients. *Canadian Journal of Psychiatry* 64(8), 568-576. <https://doi.org/10.1177/0706743719828963>.
- Sabatier PA, Jenkins Smith HC. 1993. *Policy change and learning: an advocacy coalition approach*. Westview Press.
- Smetanin P, Stiff D, Briante C, Adiar CE, Ahmad S, Khan M. 2017. The life and economic impact of major mental illnesses in Canada: 2011 to 2041. Mental Health Commission of Canada. https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/MHCC_Report_Base_Case_FINAL_ENG_0_0.pdf.
- Statistics Canada. 2013. Canadian community health survey: mental health, 2012. <https://www150.statcan.gc.ca/n1/daily-quotidien/130918/dq130918a-eng.htm>.
- Taylor P. 2015. Why do I have to wait so long to see a psychiatrist in Canada? Healthy-Debate.ca. <https://healthydebate.ca/2015/03/topic/wait-psychiatrist-in-canada/>.
- Teotonio I. 2018. Province should fund psychotherapy by non-doctors, says provincial agency on health quality. *Toronto Star*. https://www.thestar.com/life/health_wellness/2018/01/15/province-should-fund-psychotherapy-by-non-doctors-says-provincial-agency-on-health-quality.html.
- Trusler K, Doherty C, Mullin T, Grant S, McBride J. 2006. Waiting times for primary care psychological therapy and counselling services. *Counselling and Psychotherapy Research* 6(1), 23-32. <https://doi.org/10.1080/14733140600581358>.
- Turner J, Hayward R, Angel K, Fulford B, Hall J, Millard C, Thomson M. 2015. The history of mental health services in modern England: practitioner memories and the direction of future research. *Medical History* 59(4), 599-624. <https://doi.org/10.1017/mdh.2015.48>.
- Tyrer P. 2014. Two cheers for psychotherapy. *The Lancet* 384(9949), 1176-1177. [https://doi.org/10.1016/S0140-6736\(14\)61713-X](https://doi.org/10.1016/S0140-6736(14)61713-X).

- United Kingdom Parliament. 2006. Activity, performance and efficiency (continued). <https://publications.parliament.uk/pa/cm200506/cmselect/cmhealth/1692-i/169263.htm>.
- University of Toronto Psychiatry. 2020. Bringing accessible psychotherapy to more Ontarians. <https://www.psychiatry.utoronto.ca/annual-report-accessible-psychotherapy>.
- Urbanoski K, Inglis D, Veldhuizen S. 2017. Service use and unmet needs for substance use and mental disorders in Canada. *Canadian Journal of Psychiatry* 62(8), 551-559. <https://doi.org/10.1177/0706743717714467>.
- Weible CM, Cairney P. 2018. Practical lessons from policy theories. *Policy & Politics* 46(2), 183-197. <https://doi.org/10.1332/030557318X15230059147191>.
- Weitz E, Kleiboer A, van Straten A, Cuijpers P. 2018. The effects of psychotherapy for depression on anxiety symptoms: a meta-analysis. *Psychological Medicine* 48(13), 2140-2152. <https://doi.org/10.1017/S0033291717003622>.
- Xierali IM, Tong ST, Petterson SM, Puffer JC, Phillips RL, Bazemore AW. 2013. Family physicians are essential for mental health care delivery. *The Journal of the American Board of Family Medicine* 26(2), 114-115. <https://doi.org/10.3122/jabfm.2013.02.120219>.
- Zahn C. 2016. Time to take action on mental health. *Toronto Star*. <https://www.pressreader.com/canada/toronto-star/20161015/283308932005289>.

7 APPENDIX A

Program	Contrasting Details	Common Details
IASP (The Royal, 2020; IASP CBT Training Program, 2020; CAMH 2019, 2020)	<ul style="list-style-type: none"> -Coordinated through four speciality mental health hospitals (Waypoint Centre for Mental Health Care, CAMH, Ontario Shores Centre for Mental Health Sciences, Royal Ottawa Health Care Group), which are responsible for training and clinical consultation -Also available remotely through the Ontario Telemedicine Network -Focused on individuals with mild to moderate depression and/or anxiety -Use of weekly symptom measurements -All therapists must be members of appropriate regulated health professions (i.e., medicine, social work, nursing, psychology, occupational therapy) -All therapists must have completed intensive CBT training: a series of CBT courses on anxiety and depression using a blended format (e-learning modules + in-person application activities), accredited through the University of Toronto as a certificate program, following the Canadian Association of Cognitive and Behavioural Therapy guidelines. Courses include: 1) Fundamentals of CBT (10 interactive modules, 40+ CBT skills videos, in-person activities, discussion boards, readings, reflections, assignments, peer/facilitator interaction); 2) Clinical Consultation for CBT; 3) CBT for Depressive Disorders; and 4) CBT for Anxiety & Anxiety-related Disorders -All therapists must be supervised by a PhD clinical psychologist with CBT expertise -Approximately 12 sessions in length 	<ul style="list-style-type: none"> -Target population is adults (18+) -Offers in-person and group services -Program is in partnership with community-based providers (e.g., universities/colleges, primary care providers, family service agencies, community mental health agencies) -Operates in a stepped-care model

IAPT (NHS, 2019)	<ul style="list-style-type: none"> -Focused on individuals with a range of mental health diagnoses (anxieties, depressions, obsessive-compulsive disorder, phobias, post-traumatic-stress disorder) -Length of treatment varies -IAPT clinicians must have fulfilled an IAPT-accredited training program, with nationally agreed requirements aligned to NICE guidelines, therapists are accredited by relevant health profession organizations -Low-intensity practitioners/psychological wellbeing practitioners (PWP): All PWPs have completed an IAPT training course, core IAPT low-intensity courses for PWPs accredited through the British Psychological Society, have fulfilled relevant IAPT continuing professional development course -High-intensity therapists: Need to have been trained in a particular therapy that they provide in an IAPT setting with professional accreditation with the relevant health practitioner organization 	
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