Day of Action 2024
Mental Health Care Access

Delegate Background Guide

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CURRENT POLICY LANDSCAPE AND ONTARIO'S ROADMAP TO WELLNESS

Each year, more than one million people in Ontario require mental health/addictions care and many experience challenges in accessing timely and appropriate services.[1,2] This has been the catalyst for a mental health crisis in the province, with the patchwork nature of the mental health care system unable to adequately meet the mental care needs of Ontarian's. The most significant barriers include the cost of psychological therapy, long wait times, disconnection across different settings and providers, regional differences in service access/quality and a lack of data preventing accountability and transparency.[3] Moreover, racialized, Indigenous and other marginalized populations face considerable challenges in accessing trauma-informed, culturally sensitive and decolonized care.[4] As a result of these barriers, there has been an increasing utilization of the Emergency Department (ED) for mental health and addictions care, with a 47% increase between 2009-2017.[5]

The current policy landscape in Ontario has seen advancements with the province nearly halfway through the 10-year "Roadmap to Wellness" plan which began in 2020. The Roadmap to Wellness was a groundbreaking $3.8 billion investment over 10 years to reform and build a mental health and addictions systems for Ontario.[6] One of the pillars of this plan is the implementation of the Ontario Structured Psychotherapy Program (OSP) which provides in-person/virtual cognitive behavioural therapy for mild depression and anxiety. Funded similarly to OHIP, there are no out-of-pocket costs and the program is delivered through network lead organizations and community partners across the province. The emphasis on a program like the OSP recognizes the considerable financial barriers to accessing psychotherapy and aims to reduce inequities in access based on socio-economic status.

A second pillar in The Roadmap to Wellness focuses on children/youth. For the 10-21 year old age group, there was a ~90% increase in the rate of ED visits between 2009-2017 and 28 000 children are now on the waiting lists for mental-health care. Moreover, there are significant differences in access depending on the type of service required with some forms of treatment requiring a 2.5 year wait.[7] To address these wait times, the province has invested in Youth Wellness Hubs which provide walk-in access to mental health and addiction services and primary care providers.[8] However, these services are preliminary and children/youth in need of more intensive forms of treatment are further referred to appropriate providers. In 2023-2024, the Province also invested an additional $114 million in school-based mental health and introduced curricular changes to increase mental health literacy.[9, 10]

The Roadmap also recognizes the fragmented nature of the mental healthcare system. Currently, there are ~600 community based organization providing care that significantly vary in quality and there is a lack of integration between hospitals, community care and primary care.[11] Transitioning between these settings can be challenging and there are increased risks of relapse during the post-discharge period.[12, 13] Primary care can play an integral role in coordinating across the continuum of care and navigating across disconnected systems.[15]

However, current funding models do not fully incentivize team based care and adequately support the provision of mental health services within primary care settings.[14]

Another systemic challenge to the mental health and addictions system is significant regional variations in service quality. Furthermore, ongoing colonialist practices have created considerably poorer mental health outcomes for Indigenous populations living in remote reserves in Northern Ontario. In the North West Local Health Integration Network (LHIN), children/youth suicide rates are six times higher than the other LHINs. Wait times are also the longest and there are ongoing challenges with recruiting/retaining physicians and other allied mental health care professionals.[16] In response to this, the province has invested in Mobile Mental Health and Addictions Clinics, which aims to bring services to those living in rural and remote communities who have geographical challenges with accessing care.[17] Furthermore, the province has recently invested $2.6 million in the Nishnawbe Aski Nation (NAN) which represents 49 First Nations and ~45 000 Indigenous peoples, aiming to scale up and strengthen the capacity of mental health and addictions services in these communities.[18]

The Roadmap emphasizes the role of data in creating greater accountability, integration and standardization in the delivery of mental health care services. There are currently significant gaps in measuring the performance of the mental health care system and some of the current funding allocation is based on historical precedents.[19] To address this, the Canadian Institute of Health Information (CIHI) is developing indicators to assess wait times for community services, the frequency of emergency department visits, rates of self-harm…etc.[20] This will allow the Province to better determine if they are indeed meeting their goals and to better tailor their funding towards filling systemic gaps, improving access and delivering care that is equitable across regions and populations. Data will also drive greater integration by allowing for the sharing of health information across providers and settings, making transitions between different sectors within the system more seamless.[21]

POLICY GAPS AND OPPORTUNITIES FOR ADVOCACY

Despite these policy advancements, gaps in the current mental health landscape are notable. The annual spending on mental health and addictions programs in Ontario is $2.2 billion or around 7% of the Ministry of Health budget. With mental illness contributing to ~ 10% of the burden of disease in Ontario, mental health care is underfunded by ~$1.5 billion.[22] The Mental Health Commission of Canada suggests increasing mental health care spending to ~9% of the health care budget, which would be commensurate with other Organisation for Economic Co-operation and Development (OECD) countries that spend 10–11% of the budgets on mental health care.[23]

In addition to increasing the proportion of the health care budget allocated to mental health, further policy advancements are needed to fill systemic gaps in the mental health care system. Although the OSP is an important step towards more equitable access to psychotherapy, it is limited by long wait times which are greater in remote and Northern areas, stringent exclusionary criteria, restricted therapeutic modalities and a youth program that is primarily virtual and self-

directed.[24] Secondly, despite measures to strengthen the mental health care system for children/youth, average wait times for psychotherapy are ~2 months and for more specialized, intensive care it is ~3 months.[25] Furthermore, a report from People for Education, a Toronto based non-profit research institute, found that the percentage of schools with no access to psychologists has more than doubled over the past 10 year, with particularly acute shortages in rural and remote areas.[26] More investments in community based treatment programs and school based care are critical to abating the worsening crisis. Thirdly, there must be greater integration across settings and providers. Ontario Health Teams, which encompass hospitals, primary care physicians, and community organizations, is an innovative model put forward by the Province to achieve better integration.[27] Other promising initiatives include establishing the infrastructure to support data sharing and supporting the provision of mental health services in primary care settings. Finally, to reduce regional inequities, there must be continued investment in the OSP Program in Northern Ontario, robust incentives to retain/recruit mental health professionals and the expansion of virtual mental health care coverage to include allied health providers.

TRAUMA INFORMED, ANTI-OPPRESSIVE & DECOLONIZING FRAMEOWRK

A trauma-informed, anti-oppressive/identity affirming and decolonizing framework should underlie all forms of mental health care and guide the delivery of programming. Providing trauma-informed care includes services that recognize the need for creating a physically and emotionally safe environment, ensuring patient autonomy in managing treatment, and preventing re-traumatization of the individual.[28] Anti-oppressive/identify affirming practices are attuned to the systems of oppression that intersect to disadvantage and harm individuals along the axes of race, gender, age and disability. By providing mental health care that amplifies the voices of marginalized and vulnerable populations and engages with cultural humility, oppressive systems are challenged that perpetuate further psychological distress.[29] Finally, a decolonizing framework aims to centre Indigenous caregivers and practices in the delivery of care, affirming self-determination and de-centring paternalistic practices. Providing mental health care exclusively from a Western medicine lens can contribute to further trauma and distress in Indigenous populations while exacerbating pre-existing inequities.[30]

ASK 1: Adapt and expand the Ontario Structured Psychotherapy Program

- **Continued investments to reduce waiting times, especially in Northwestern Ontario.**
- **Relax exclusionary criteria and offer in person/virtual therapy for those aged 10-17.**
- **Continued performance measurement to advance health equity goals.**

The Ontario Structured Psychotherapy (OSP) Program is publicly funded and provides cognitive behavioural therapy free of cost for those who are suffering from mild/moderate anxiety and depression. It is overseen by 10 network lead organizations across Ontario who work with community organizations, local hospitals and healthcare professionals in their respective regions. The OSP began as a pilot program in 2017 with Waypoint Centre in Central Ontario, CAMH in Toronto, the Royal Ottawa Mental Health Centre and Ontario Shores Centre in Eastern Ontario. The provincial government has since expanded the program with additional network lead organizations in Western Ontario, Northwestern Ontario, Northeastern Ontario and Central Ontario.[31]

The currently available therapeutic modalities are individual/group based CBT which is offered in weekly 1-hour in-person/virtual sessions. Participants are eligible for 10–12 sessions and must wait a minimum of 3 months before a second round of therapy is provided.[32]There are also stringent exclusionary criteria: Participants must be over 18 years, not currently engaging in self-harm, no experience of psychosis/mania in the past year, no evidence of concurrent or eating disorders, and not diagnosed with a complex personality disorder.[33] For those 15-17 years old, OSP offers BounceBack, a form of telephone coach assisted therapy where participants engage in self-directed CBT skill building through workbooks and online videos.[34] Furthermore, network lead organizations have partnered with Indigenous community organizations through the Minookmii pathway, offering adaptations of CBT that are attuned to intergenerational trauma and the impact of settler colonialism.[35]

Although the OSP has significantly improved mental health care access for those experiencing anxiety and depression, additional adaptations and continued investments are needed to improve its impact. There are still significant wait times , with St. Joseph's Care Group the OSP Provider in Northwestern Ontario reporting wait times of a few weeks to a few months depending on the service.[36] Secondly, those aged 10–17 should have the opportunity to receive weekly in-person/ virtual CBT based psychotherapy. BounceBack, in being primarily self guided, puts the onus on the participant and presumes a requisite level of motivation/self-efficacy which may be lacking in those experiencing depression/anxiety. Thirdly, the exclusionary criteria should be relaxed and there should be an attempt to include a wider spectrum of mental illnesses such as personality disorders and eating disorders. Moreover, a broader range of therapeutic modalities should be offered beyond CBT-based psychotherapy. Mental illness does not exist in a siloed way and there are often multiple co-morbid conditions. Providing dialectical behavioural therapy (DBT) for those with borderline personality disorder or tailored forms of CBT for those suffering from eating disorders recognizes the complex, multi-dimensional nature of mental illness. Fourthly, there must be continued emphasis on offering trauma informed, decolonized and anti-oppressive

forms of care. To facilitate this, network lead organizations should allow community organizations the latitude to adapt the OSP to better meet the needs of racialized and Indigenous populations. The Minookmii pathway offers longer sessions, integrates storytelling and provides Sacred Circle CBT where Western and Indigenous approaches are offered as complementary paradigms. Similar adaptations to meet the needs of other marginalized and vulnerable groups will be necessary in order to create more equitable mental health outcomes.[37]

In alignment with the Roadmaps's emphasis on the role of data in facilitating quality improvement, information is collected such as gender, sexual orientation, racial/ethnic group and financial status.[38] The Province must continue to prioritize performance measurement in order to further bolster the effectiveness of its interventions and to advance health equity goals. Since the quality of mental health care services can vary considerably across regions, OSP should be monitored for geographical disparities in delivery across the network lead organizations (especially in Northwestern and Northeastern Ontario). Measurement Based Care is also an integral part of the Program, allowing for progress to be assessed and the effectiveness of the treatment to be gauged. The Province should use this data to determine whether there are differences in the quality of care for marginalized and vulnerable groups-this can then inform the development of targeted adaptations to allow for more culturally sensitive forms of care. Furthermore, to facilitate greater integration across service providers and settings, this data should be readily available to the individuals primary care physician and other providers throughout the continuum of care.

ASK 2: Enable children/youth to access mental health services within 30 days.

- **Strengthen the capacity and standardize the quality of community based programs.**
- **Continued investments in school-based mental health care.**

The number of children and youth on wait lists for mental health care in Ontario has more than doubled from 12 000 in 2017 to 28 000 currently. The average wait time for counselling is two months and for more long term, intensive forms of therapy it is over 3 months.[39] As a result, children and youth have been seeking treatment in the ED—between 2009-2017, there was a ~90% increase in the rate of hospitalizations.[40] Once they have been discharged, there is a high risk of needing acute interventions again as they return to waiting lists. The urgency of the crisis precipitated Bill 53 (second reading) which calls for any one under the age of 26 who has been designated as needing mental health services to be able to access care within 30 days.[41] In order for this to be realized, we are calling for strengthening the capacity of community based programs and continued investments in school-based mental health care.

As outlined in Ask 1, allowing those aged 10-17 to access psychotherapy through the OSP Program can be an important mechanism in improving access and preventing potential exacerbations. For those with more serious and complex issues, there are also significant gaps in community care with a lack of in-home services, day treatment and residential treatment.[42]

Eating disorder hospitalizations, for example, now account for a considerable proportion of overall mental health hospitalizations.[43] Children and youth with these disorders need intensive interdisciplinary treatment and ongoing family support, such as CBT-E and family based therapy (FBT). Youth experiencing psychosis also often experience inconsistencies in service at Early Psychosis Intervention (EPI) Sites across the Province, leading to higher risks of suicide and other adverse outcomes. CAMH has been advocating for standardizing the quality of care by integrating an evidence based program called NAVIGATE into the programming at all 52 EPI sites.[44] NAVIGATE consists of individualized pharmacotherapy, working collaboratively with the family, individual resiliency training and guidance/mentorship to achieve educational and employment goals.[45]Scaling up the delivery of this program will better enable youth to receive accessible, long term and evidence based care during their recovery from psychosis.

Youth Wellness Hubs Ontario (YWHO) is an initiative spearheaded by the Province to provide walk-in, low barrier care to youth aged 12–25. Spanning across geographical regions and culturally diverse contexts, there are currently 22 YWHO Hub Networks offering mental health services, primary care, and educational/employment/recreational services in an integrated care setting.[46] It importantly uses Measurement Based Care, where information is collected from youth to empirically assess the effectiveness of the services that have been provided.[47] The YWHO aims to ease disruptions in the continuity of care, with youth often experiencing significant challenges as they transition into needing adult services and can also serve to offer bridging support if further community/hospital based treatment is required.[48] We call on the Province to invest in additional YWHO Hub Networks with continued performance measurement assessing its impact on reducing ED visits, accessibility to youth, disparities across racial/gender/regional lines and the effectiveness of its interventions. Barriers identified to implementing Measurement Based Care at YWHO, such as concerns of confidentiality and the overwhelming administrative burden on youth, should be addressed through streamlining the information collection process and ensuring data security is prioritized.[49]

Investments in school based care are also an important cost-effective mechanism in improving access. A Multi-Tiered System of Support (MTSS) is offered with different types of interventions provided based on the severity and acuteness of the mental health issue. Tier One is centered on mental health promotion and early identification, where an affirming and welcoming classroom environment is fostered and students exhibiting early signs of mental distress are connected to appropriate resources. In Tier Two, school mental health professionals provide short-term interventions to aid students with navigating mild/moderate mental health issues. In Tier Three and Four, students who are experiencing complex, acute and severe issues are transitioned to more intensive services in the community or the hospital.[50] Recognizing the importance of school based care, the Province invested an additional $114 million in 2023–2024 and in 2023 announced that it was introducing mental health education into the curriculum for elementary and high school students. [51]

Although these are significant and important measures, there are many areas for advocacy and improvement. Firstly, mental health education to dispel stigma and normalize the experiences of

those who are not mentally well can sometimes have the unforeseen consequence of entrenching further stigma through a "rebound effect-rigorous measures should be used to assess the effectiveness of these interventions.[52] Secondly, the percentage of schools without access to psychologists has more than doubled over the past ten years and the recommended ratio of psychologists (1:250) and mental health workers (1:375) to students has been exceeded at many schools. Additional social workers and psychologists are needed, especially those from diverse backgrounds in order for culturally sensitive care to be provided. Thirdly, transitions from school to community programs are fraught with risk and the potential for the worsening of mental health issues.[53] It is imperative that these transitions be bridged with additional supports and they be timely to avoid significant interruptions in the continuity of care. Fourthly, data collection is necessary to assess the quality and availability of mental health supports-this could include ratios of mental health workers to students, wait times, and which students are accessing services. This will allow for greater accountability in delivery and enable quality improvement.[54]

ASK 3: Create greater integration across different settings and providers.

- **Continue to approve additional Ontario Health Teams.**
- **Develop the infrastructure to support data sharing across hospitals, community care and primary care.**
- **Incentivize the provision of mental health services within primary care settings.**

Following an acute mental health crisis requiring hospital admission, patients that are discharged are at a considerable risk of experiencing a relapse or self-harm/suicide.[55] Readmission after 30 days is a metric that is used to assess the quality and accessibility of primary/community care and in 2022/23 around 13% of patients with a mental health issue in Ontario were readmitted within 30 days.[56] There is often a lack of communication between hospitals, primary care and community services, and many hospitals do not provide adequate guidance to their patients on the types of community programs that can be accessed.[57] Moreover, primary care physicians often do not have information shared to them from hospitals about when their patients are admitted or discharged, which hinders the provision of follow up care and support. In response to this lack of integration, the Province introduced Ontario Health Teams to create greater coordination and more seamless transitions between hospitals, community care and primary care. A Health Team consists of hospitals, primary care physicians, allied mental health care professionals and community/home care providers who work collaboratively to provide a continuum of care to a specific geographic region. There are currently 58 teams across the Province which can provide more continuous and supportive care, easing navigation of the system.[58] We call on the Province to continue to expand this innovative model of care which will foster a greater sense of interconnection across the mental health system.

The Roadmap also stipulated that a mental health and addictions data repository should be established so that data could be shared securely among different providers and across different care settings.[59] Patients also often remark how they must share their mental health experience

multiple times, leading them to feel less validated and supported. As envisioned, the MHA Provincial Dataset will provide reporting on the clients social determinants of health, what core services they have received, from what organizations/sites/providers and when the referral/ service delivery occurred. Moreover, through advanced analytics, it will also provide an assessment of the effect of the services, what combination of services has been most successful and monitor wait times and living conditions during the course of their treatment.[60] In addition to creating greater integration, the MHA Provincial Dataset will allow for accountability, provide opportunities for quality improvement and performance measurement, and enable more appropriate funding allocation.

The provision of mental health care within a primary care setting can significantly reduce hospital admissions through early detection, treatment and mental health promotion.[61] Primary care physicians are also positioned to be involved throughout the continuum of care, providing accessible and timely follow up after hospital discharge and guiding their patients as they navigate across different care providers and settings. Although the fee-for-service model (FFS) is the predominant funding model in Canada, a blended capitation model can incentivize team-based care, continuity and greater time with patients experiencing more complex mental health issues.[62] In blended capitation, each rostered patient is assigned a capitation rate based on age, gender, projected utilization and complexity and this is received up front. Physicians also receive 15% of the FFS rate for each in-basket service provided to enrolled patients and 100% of the FFS rate for any out-of-basket services. In addition, there are incentive payments for providing mental health services after hours, on weekends or on holidays. Importantly, if a rostered patient seeks care elsewhere for in-basket services, the clinic is negated or penalized at 100% of the FFS rate for that particular service.[63] This promotes continuity of care with ongoing monitoring and follow-up. Furthermore, primary care physicians are able to form government-funded interdisciplinary teams with other allied mental health professionals. The additional income that the clinic earns under blended capitation can also go towards expanding the interdisciplinary team since that will add more patients to the roster.[64] We call on the Province to continue to adjust primary care compensation models to incentivize interdisciplinary, team-based practice and the enrollment of those with complex mental health issues.

ASK 4: Improve service quality and access for rural and Northern communities across Ontario.

- **Continued investment in mobile mental health clinics and the OSP Program in Northern Ontario.**
- **Increase the recruitment and retention of mental health professionals.**
- **Expand coverage of virtual mental healthcare to include allied healthcare providers.**

Rural and Northern communities in Ontario face considerable health care challenges stemming from social (food insecurity, housing, education...) and ecological determinants of health (climate impacts and geographical remoteness). These challenges are exacerbated for the Indigenous populations of these communities as a result of continuing colonialist practices. It has been noted that Canadians who live in remote and underserved communities have significantly worse mental

health outcomes with a greater prevalence of suicide and self-harm.[65] Despite these profound health disparities, only 13.6% of family physicians and less than 3% of specialists reside in Rural and Northern communities. Geographical remoteness acts as a significant health determinant with residents from these communities traveling on average 10 km to see a physician in comparison to 2 km for urban residents.[66]

To address these barriers to accessing care, the Province has invested in mobile wellness clinics which travel directly to remote and rural communities. Staffed by an interdisciplinary team of mental health professionals, these clinics provide psychotherapy, psychiatric support, medication management, addictions care and referrals to more specialized and intensive services in the region.[67] We call on the Province to continue to invest in this service, and to prioritize expanding its availability. In October 2023, the Ontario government expanded the OSP program to the Northwest, making psychotherapy available to remote communities in the Thunder Bay region. However, wait times range from weeks to months and more community organizations are needed to partner with St. Joseph's Care Group, the network lead organization in Northwestern Ontario.[68] Many "fly-in" Reserves in Northern Ontario continue to grapple with a lack of adequate mental health supports stemming from colonialist practices and geographical remoteness. For example, Pikangikum, an Indigenous Reserve in Northern Ontario, was reported to have one of the highest suicide rates in the world in 2012.[69] A greater Provincial investment beyond the $2.6 million given recently to the Nishnawbe Aski Nation (NAN) is needed in order to bolster the capacity of mental health and addictions services in these communities.

Canada has faced considerable challenges in recruiting and retaining physicians to rural and Northern areas. In 1996, only ~10% of physicians worked in these communities even though over 22% of Canadians lived there. In a second study, Geographic Distribution of Physicians in Canada: Beyond How Many and Where (2004), there was no significant improvement with ~9% of physicians in rural/Northern areas. In the most recent study completed in 2016, it was found that ~8% of physicians (~14% of family physicians and ~2% of specialists) worked in rural/ Northern Canada with ~19% of Canadians living in those areas. What is striking about this longitudinal data on the geographical distribution of physicians is that there has been no meaningful change since 1996.[70]

To increase the recruitment and retention of mental health professionals, we call on the Province to expand loan forgiveness programs to include other allied health care workers such as psychologists, social workers and nurses. Given that there has been no meaningful change in physician recruitment and retention in decades, allied healthcare professionals can help to fill this systemic gap. Many healthcare professionals also often struggle to integrate into rural and Northern communities. Contributing factors include inadequate housing, and challenges with finding employment opportunities for their partners. Housing subsidies and spousal support can facilitate integration and increase the likelihood of healthcare professionals remaining in these communities.[71]

The Ontario Telemedicine Network (OTN) is currently funded by the Provincial government. It provides care using a secured telecommunications connection for those at a designated site (hospital, community health care setting) with the IT infrastructure to support OTN.[72] Although this service is promising in bridging geographical barriers, it can also perpetuate and re-inscribe existing inequities. It may be difficult for someone to travel to access OTN at the designated sites and without the requisite level of digital health literacy, navigating the technology may prove challenging. Furthermore, wait lists can be considerable given that the funding only covers care when it is delivered by a physician or a psychiatrist. Expanding coverage to include other allied mental health professionals can contribute significantly to reducing waiting times.

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