Commentary: Minding the Gap in Access to Mental Health Services – Calling for Smart Funding, Not Just More Funding

Commentaire : Combler l'écart dans l'accès aux services de santé mentale – appel à un financement intelligent, pas seulement plus de financement

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Abstract

In response to the paper by Gatov and colleagues (2023), the authors of this commentary, both psychiatrists, consider ways of addressing long-standing gaps in access to mental health services in Canada. They note the innovation seen during the COVID-19 pandemic with the rise of virtual care because of viral threat and economic imperative. Drawing on examples, including the UK-based experiment with publicly funded psychotherapy, they discuss the need for more flexible provider models of care (read: non-physician), better data collection and the potential of artificial intelligence. They conclude by calling for smarter funding, not just more funding.

Résumé

En réponse à l'article de Gatov et ses collègues (2023), les auteurs de ce commentaire, tous deux psychiatres, envisagent des façons de combler les lacunes de longue date dans l'accès aux

services de santé mentale au Canada. Ils soulignent les innovations observées pendant la pandémie de COVID-19 avec l'augmentation des soins virtuels en raison de la menace virale et des impératifs économiques. En s'appuyant sur des exemples, notamment l'expérience britannique en matière de psychothérapie financée par le secteur public, ils discutent de la nécessité d'avoir des modèles de soins plus flexibles (comprendre : autre que par des médecins), préconisent une meilleure collecte de données et commentent le potentiel de l'intelligence artificielle. Ils concluent en demandant un financement plus intelligent, pas seulement plus de financement.

Introduction

We applaud the focus of Gatov et al. (2023) on addressing long-standing gaps in access to mental health services through innovations – and not (just) because they cited a previous publication of ours repeatedly!

If the COVID-19 pandemic was a great revealer of inequities in access to healthcare in general, it is also true that the same pandemic has appeared to be an accelerator of innovation from vaccines to virtual services. As Gatov et al. (2023) note, it has been "another window of opportunity for healthcare reforms through the rapid adoption and routinization of digitization" (p. 44). The reality is that in the same spirit that it takes years of work for something to become an overnight sensation in entertainment, many of these innovations had a pre-COVID genesis. Virtual psychiatry via television was first reported in the peer-reviewed literature in 1957 (Tucker at al. 1957). Prior to the pandemic, while only 7% of Ontario psychiatrists worked via that technology regularly (Serhal et al. 2017), many had been exposed to virtual care in their training or at points in their practice. Of course, the pandemic was transformative; virtually, all psychiatrists became virtual psychiatrists, for example, but the seeds of change were sown over the past decades.

This represents a significant turning point in patient-centred care, precipitated by both viral threat and economic imperative, that will endure longer than the pandemic as an enhanced menu of options and choices for patients to engage in healthcare. And, at the level of provinces and territories, there needs to be a commitment to continue public funding of this healthcare access option, as well as ensure broadband access across their jurisdictions to make it work properly.

Discussion

With regard to human mental health resources, Gatov et al. (2023) rightly point out the now-dated origins of the *Canada Health Act* (1985) that reflected the idea that healthcare was to be delivered primarily by physicians and in hospitals. Hospitals have largely become the last refuge of fully publicly funded, multidisciplinary mental healthcare, which includes nurses, psychologists, social workers, occupational therapists and others.

In March 2023, the Canadian Alliance on Mental Illness and Mental Health released its national survey of perceptions of access to mental healthcare in Canada during the pandemic

(Mental Health Research Canada 2023). Almost half of the Canadians gave their jurisdiction a failing grade in terms of access for all residents. Only one-third of those who did access services obtained publicly funded ones; for the remainder, it was a mix of out-of-pocket and privately insured services. They overwhelmingly endorsed expectations of reasonable wait times, something for which precious little data in Canada exist.

While Gatov et al. (2023) point to the reality that private insurance coverage often covers a minimal number of therapy sessions, there are examples of changes in the banking and telecommunication sectors, where unlimited mental health coverage for treatment with registered professionals is now being advertised for recruitment – secure in the evidence that this investment in the mental health of employees is associated with a reduction in workplace disability costs. What will it take to expand outpatient, publicly funded coverage of multidisciplinary, evidence-based mental healthcare with measurement of net cost, much as has been recently demonstrated with regard to the impact of free medicine distribution on reducing overall healthcare costs?

Our system is generally structured around primary care, itself a focus of concern given the significant number of people without access to this essential resource. In terms of mental health, there is a double barrier – not only in finding a primary care provider but also in that provider then being able to find mental health resources for referral if needed. One of the striking aspects of the Improving Access to Psychological Therapies (IAPT) program (NHS England n.d.) in England as a fully publicly funded psychotherapy initiative, which is mentioned by Gatov et al. (2023), is that self-referral is allowed, removing one of the barriers. It does not preclude primary care involvement, but it does not necessitate it either.

The other striking feature of the IAPT program is its use of a new cadre of providers called psychological well-being practitioners. They do not have the advanced training (or the years required to complete it) of the traditional mental health disciplines. They are trained intensively and rapidly. And unlike the traditional disciplines, they are closely supervised, monitored and evaluated with regard to clinical volumes and, importantly, clinical outcomes. The idea that there are standardized outcome data on 98.5% of clinical encounters in a national health initiative is currently unimaginable in Canada (Clark 2018). And then there is accountability. This aggregated information is publicly available on websites, from waiting times to measures of improvement and recovery.

In recent years, Ontario has moved to the regulation of psychotherapists through a provincial college. This change represents another public safeguard around standards and accountability beyond what is built into microsystems of care, such as the IAPT program. If provinces are open to the implementation of this proven model of improved access and care, they also need to fund it.

But even with training new providers, both traditional and novel, there will not be enough to meet clinical need. This is where digital interventions can play an important adjunctive role.

Self-help and bibliotherapy have a long pre-pandemic history. *Mind over Mood*, a depression self-help book (Greenberger and Padesky 2016), was in its second edition well before the COVID-19 virus was in its first edition. However, this reflects a one-size-fits-all approach that can now be tailored through the same digital technology that suggests shows for streaming based on what you have just watched.

Internet-delivered cognitive behavioural therapy (iCBT) began more than two decades ago, and a 2020 systematic review and meta-analysis demonstrated it to be as effective clinically as in-person cognitive behavioural therapy (CBT), with advantages in terms of accessibility, flexibility and potential cost-saving (Etzelmueller et al. 2020).

Given the ubiquity of smartphones globally (roughly 80% of the world's population have them), there is a need to leverage their potential. There are now over 10,000 mental health apps, most of which have been subject to little-to-no scrutiny in terms of efficacy, privacy and other concerns. Nevertheless, some apps have been evaluated and are either proven or promising, offering help for conditions where waitlists are long (post-traumatic stress disorder) or which cut across all mental health diagnoses (insomnia). Some of these apps employ artificial intelligence (AI), which allows for the ultimate digital customization of interventions to the individual.

These low-cost interventions can vault over many of the access hurdles, although there are caveats beyond concerns around efficacy and privacy. First, there are those people on the wrong side of the digital divide who do not have the hardware, software, technological skills, money or housing to use these services. Then there are the growing fears regarding AI in the ChatGPT (https://openai.com/blog/chatgpt) world; while the need for brakes on its evolution are important, it is clear that there will be no full stop in AI development, and even cautionary voices, such as Geoffrey Hinton, have endorsed its potential for healthcare benefit in a recent interview (Goodyear 2023).

These interventions do not replace human clinicians but rather provide another entry point in a stepped level of care, and may provide more contemporaneous monitoring of signs and symptoms than our expectation that patients accurately recall them at a subsequent appointment weeks or months later. With regard to guild-like fears of replacement, someone has noted that you cannot replace what does not exist for too many of us.

The need for Canada to increase its percentage of health funding that goes to mental health is emphasized by Gatov et al. (2023) and was part of the national mental health strategy created by the Mental Health Commission of Canada (MHCC) over a decade ago. It has not yet happened, and as Gatov and colleagues (2023) point out, mental health spending is about 7 cents on the healthcare dollar today. However, we add that for the desired improvements, this funding boost cannot be another Canadian example of just adding more money to the existing patchwork of services. It needs to be tied to meaningful measures of access (who is helped and how quickly), outcomes (standardized measures that are accountable publicly in aggregate form) and innovative approaches. Easier metrics to count – the number of hospital

beds, the number of providers – are not sufficient. We need to know if people got help and got better, and we need innovative approaches beyond our existing resources.

Conclusion

The pandemic has presented healthcare delivery, in general, and mental healthcare delivery, in particular, with an opportunity to innovate and expand access. To fully capitalize on this moment, we need smarter funding, not just more funding. A first step is implementing the MHCC's recommendation of 9% of health funding (MHCC 2012). However, the past decades have been rich in examples of more funding not resulting in better care. Thus, we need to push further to fund evidence-based initiatives, with clear public accountability for that new funding. Gatov et al. (2023) note the need to address gaps in access with innovation. We believe that goal is possible, but there is work to do.

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