Fifteen Years of Internet-Delivered Cognitive Behaviour Therapy in Saskatchewan: Expanding Access to Evidence-Based Care

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Abstract

Internet-delivered cognitive behavioural therapy (ICBT) is the most researched form of digital mental health care, with strong evidence across diverse conditions. This article presents 15 years of ICBT implementation in Saskatchewan through the Online Therapy Unit (OTU), Canada's longest-running publicly funded ICBT service. With over 14,300 clients served, the OTU integrates service delivery and research, offering transdiagnostic and condition-specific courses with brief therapist support. Key facilitators include program credibility, adaptability, strong partnerships, dedicated infrastructure and personnel and a learning health system approach. Challenges include evolving technological expectations and improving public awareness. The OTU provides a compelling model for scaling ICBT.

Introduction

Cognitive behavioural therapy (CBT) is a well-established evidence-based treatment for a range of mental health conditions (Cuijpers et al. 2025). However, similar to other forms of therapy, access to CBT is often hindered by provider availability, logistical challenges (e.g., location, time or cost) and concerns about privacy. Internet-delivered CBT (ICBT) was developed to expand access to CBT by providing structured treatment materials online, often supplemented with brief therapist support in routine care to assist clients in developing skills for managing mental health concerns.

There is now a substantial body of research in support of ICBT, with numerous systematic reviews and meta-analyses demonstrating its efficacy (for a recent umbrella review, see the article by Käll et al. 2024). In fact, meta-analytic reviews show that ICBT results in equivalent outcomes as face-to-face CBT for a range of depressive, anxiety and somatic disorders (Hedman-Lagerlof et al. 2023). Guided ICBT programs typically outperform unguided programs (Käll et al. 2024; Oey et al. 2023), with therapist support known to be particularly important for clients with moderate to severe depression (Karyotaki et al. 2021).

ICBT is now integrated into routine mental health care in several countries (e.g., Australia, Sweden, Denmark and Norway; see the article by Titov et al. 2018 for a review). In Canada, while nationwide implementation of ICBT has not been undertaken due to provincial regulatory and funding structures, free therapist-guided ICBT is available in several provinces (e.g., Ontario and Newfoundland). Saskatchewan has the country's longest-standing and most comprehensive ICBT program. This article introduces the Online Therapy Unit (OTU), outlines its delivery model and, evolving services and summarizes supporting evidence. The article concludes with a discussion of facilitators and challenges to ICBT implementation.

Introduction to the OTU

The OTU was created through a Canadian Institutes of Health Research health system improvement grant in 2010 in response to growing evidence for ICBT as a scalable, effective solution to address unmet mental health needs. Since 2015, the unit has received funding from the Saskatchewan Ministry of Health to deliver ICBT on a regular basis as part of the province's public mental health system.

The basic approach to ICBT delivery involves clients visiting our website (www.onlinetherapyuser.ca), completing an online screening, participating in a telephone screening then being assigned an ICBT course depending on client needs. Therapist guidance is provided on a weekly basis. A referral is not needed to access the services, but we communicate (through letters or phone calls) with other providers when requested, who then include this information on the client's electronic health record. The OTU complements existing care by supporting individuals on waitlists, providing additional support to clients who are concurrently taking medication or are in receipt of occasional face-to-face therapy and serving as a flexible first step to or step-down from face-to-face therapy. This model offers timely, high-quality care, improves access to mental health care, reduces burden on traditional services and meets system-wide demands for effective and scalable solutions.

Governance and management of the OTU

As the OTU is situated at the University of Regina, it is governed by university policies, for example, related to finance, human resources and research ethics. Governance is also informed by the contractual agreement with the Saskatchewan Ministry of Health, which provides strategic direction, resources and outlines service delivery expectations. Specifically, the OTU is responsible for maintaining a service delivery platform, securing and supervising staff, screening and treating clients, coordinating care with the Saskatchewan Health Authority, who also provide ICBT using the OTU platform, promoting the service across the province and conducting outcome research. Regular reporting to the Ministry of Health is required related to service utilization, outcomes and financial spending. In addition, based at the University of Regina, the unit uses a learning health system model (Institute of Medicine 2013) to guide ongoing research and iterative improvements to treatment programs, therapist practices and clinical operations. Guidance to the unit is provided by a community advisory group comprising managers from primary care and community-based organizations and community members, and a management advisory group that includes representatives from the Saskatchewan Health Authority who are also responsible for raising awareness of the OTU within their organization and throughout the province to ensure coordination of services.

Evolution of services over time

The OTU's services have evolved over time in response to research findings from our unit, as well as to better match clients' needs and preferences. The initial courses offered by the OTU were diagnostic-specific and focused on major depression, generalized anxiety and panic disorder. Although clients experienced significant improvements in their symptoms, two key limitations were identified in these original courses: (1) they did not address high rates of observed comorbidity; and (2) most clients did not complete all 12 lessons (Hadjistavropoulos et al. 2014). These limitations led us to collaborate with Macquarie University and offer several of their courses via the OTU platform, beginning with the Wellbeing Course – a transdiagnostic course that addresses comorbidities in five core lessons and includes additional resources that clients self-select based on their needs and preferences (see the article by Hadjistavropoulos et al. 2024). The course comprises slide shows, downloadable information and homework sheets, case stories and frequently asked questions. Since implementation, adapted versions of this course have also been developed for university students (Peynenburg et al. 2022b) and new and expecting parents.

Over time, the OTU expanded to offer ICBT courses for various physical health conditions, including cancer, spinal cord injuries, cardiac health concerns and chronic pain. Similar to our findings with the early diagnostic-specific courses, we noticed a need for a transdiagnostic course to address a range of physical health conditions and began offering the chronic conditions course, which follows the same structure as the wellbeing course (Mehta et al. 2022). More recently, the OTU has begun offering the sleep course – an eight-week course comprising four lessons.

In addition to the aforementioned courses, the OTU adapted a Swiss ICBT program in Saskatchewan for problematic alcohol use. The program has gone through four rounds of revisions based on client feedback and currently comprises six modules and eight additional resources to address comorbid concerns (Hadjistavropoulos et al. 2025). Most recently, the OTU has implemented two brief internet interventions with daily automated email nudges for clients who want to cultivate everyday behaviours to improve their mental health (the Things You Do lesson; Sapkota et al. 2025) or learn to support friends or family members living with depression and anxiety symptoms (the How Can I Help? lesson).

Approach to therapist support

In the OTU, ICBT is offered with brief weekly therapist support via secure written communication supplemented with phone calls if needed, consistent with models of ICBT delivery used in other online therapy clinics internationally (Etzelmueller et al. 2020). The approach challenges the assumption that clients require weekly one-hour face-to-face

therapy sessions to experience benefits. This text-based approach increases flexibility and allows clients to reflect on and write about their experiences at their own pace, an activity that can have therapeutic value. It also ensures that the written course materials remain the central focus of the treatment, reinforcing learning and skill development.

To ensure high-quality care, therapists delivering ICBT in the OTU are registered providers (e.g., psychologists and social workers) who receive specialized training and supervision in ICBT. Therapists are either employed by the OTU or by the Saskatchewan Health Authority, and are all trained in the delivery of ICBT. Regular auditing and feedback of therapist messages supports both quality assurance and development of therapists' skills (Hadjistavropoulos et al. 2020a). The OTU has developed scales for assessing desirable and undesirable therapist behaviours during ICBT. Desirable therapist behaviours include building rapport with clients, providing clear administrative instructions, offering psychoeducation, facilitating insight into CBT skills as well as supporting behaviour change through praise and encouragement of changes (Hadjistavropoulos et al. 2018). With training, undesirable therapist behaviours are infrequent and, when they do occur, typically involve failing to address client concerns or doing so only briefly (Hadjistavropoulos et al. 2019). Compared with traditional face-to-face therapy, the text-based approach is highly efficient, with past research showing eight weeks of once-a-week therapy support requires only approximately 110 minutes per client (Hadjistavropoulos et al. 2020b), with time increasing to 130 minutes when support is extended for four weeks or a booster lesson is offered (Hadjistavropoulos et al. 2022).

50% of clients request an additional four weeks of extended support following the original eight-week program, and a similar proportion access an optional booster lesson two months post-treatment.

Evidence of reach, effectiveness and client satisfaction

Over the past 15 years, the OTU has provided over 17,000 assessments and delivered ICBT to more than 14,500 clients in Saskatchewan, currently serving approximately 1,400 clients each year (as of August 2025). The primary course we offer, the Wellbeing Course, has been found effective, with clients reporting an average of a 51–56% reduction in symptoms of depression and anxiety (e.g., Hadjistavropoulos et al. 2021). Furthermore, we find that 96% of clients say that the course is worth their time, and 96% would recommend it to a friend. We have researched various aspects of delivering this course and found that client outcomes are comparable whether ICBT is offered by specialized ICBT therapists or community mental health therapists (Hadjistavropoulos et al. 2016); however, specialized ICBT therapists require less time to deliver the care. Results of the course are found to be comparable whether the course is offered with once a week support, twice a week support or support that is offered with a response within one business day (Hadjistavropoulos et al. 2020b, 2020c). In terms of duration of treatment, we have found that approximately 50% of clients request an additional four weeks of extended support following the original eight-week program, and a similar proportion access an optional booster lesson two months post-treatment (Hadjistavropoulos et al. 2022). We have identified that standardized homework reflection questions are instrumental in enhancing therapists' understanding of clients' concerns (Hadjistavropoulos et al. 2022). Notably, clients face similar difficulties with skill practice and homework in ICBT and traditional CBT (Peynenburg et al. 2022a). Another research study by the unit shows the valuable role additional resources play in assisting clients to address comorbid concerns. Around 80% of clients access additional resources (e.g., on topics such as beliefs, worry and sleep), with most clients accessing an average of five resources during the Wellbeing Course (Hadjistavropoulos et al. 2025). Beyond the Wellbeing Course, we have studied a variety of other courses within routine care. The UniWellbeing version of the course, which is tailored to the needs and experiences of post-secondary students, is also effective in improving symptoms of depression and anxiety, as well as improving academic functioning (Peynenburg et al. 2022b, 2025). The Chronic Conditions Course has also been found to improve symptoms of depression, anxiety, disability, distress, fatigue and pain-related interference among clients with diverse chronic health conditions (Mehta et al. 2022).

The Alcohol Change Course has been studied extensively and has been found to significantly reduce alcohol use, while also improving secondary outcomes such as symptoms of depression and anxiety and overall functioning (Sundström et al. 2022). In terms of operational findings, we have found that client outcomes are similar whether clients begin treatment with a brief assessment or longer interview and whether clients complete the course with or without therapist guidance (Sundström et al. 2022). Nevertheless, clients have a strong preference for therapist guidance when initiating treatment, which could impact their decision to begin treatment (Sapkota et al. 2024). Additional resources and stories are found to be important components of the Alcohol Change Course; more than 60% of clients use at least one additional resource when enrolled in the course (Hadjistavropoulos et al. 2025), and 85% of clients report that stories in the course provide meaningful benefits, including helping clients feel less alone.

Equity and inclusion considerations

User data suggest that the OTU is reaching a diverse range of clients, although opportunities remain to broaden inclusion. For example, recent research on the Wellbeing Course shows that the average client age was 39.20 years (*SD* = 13.9; range 18–83), with 70.6% of clients being female (Hadjistavropoulos et al. 2024). The majority self-identified as White (82.8%), 10.7% identified as coming from diverse ethnocultural groups and 6.4% identified as Indigenous. Compared with both Saskatchewan's population and the known prevalence of depression and anxiety in the population, some groups such as men and Indigenous Peoples remain underrepresented, pointing to barriers related to fit, awareness or access. Also notable from this recent research is that about 58% of clients who accessed ICBT reported living in communities with populations over 100,000, while 34% reported living in communities under 20,000 and 8% living in communities between 20,000 and 100,000. This distribution closely mirrors the population breakdown in Saskatchewan and suggests that the OTU is successful in delivering services across the province in a way that reflects where people live. The uptake in smaller communities underscores the potential of ICBT to reduce geographic barriers to mental health services.

The Alcohol Change Course appears to reach an even broader demographic. In recent research (Hadjistavropoulos et al. 2025), the average age of clients was 45 years (*SD* = 11.97; range 22–73), with roughly equal use of the course by men and women. A higher proportion of clients identified as Indigenous compared with the Wellbeing Course (11% vs. 6.4% Indigenous), although most still identified as White (86%) and fewer individuals from other ethnocultural backgrounds participated. While gender representation more closely reflects the prevalence of alcohol problems in the general population, some misalignment remains in terms of ethnocultural diversity. In terms of geographic reach, about 53% who accessed this course lived in communities with populations over 100,000, 27% were from communities under 20,000 and approximately 20% were from communities between 20,000 and 100,000. This course appears to be reaching a higher proportion of clients in mid-sized communities, suggesting a slightly broader geographic reach. The findings overall reinforce the potential of ICBT to extend support beyond urban centres.

Monitoring usage patterns is important to ensure that those who may benefit most from ICBT have access to it. Some groups may be unintentionally excluded due to barriers such as lack of internet access, low digital literacy, English language proficiency or cognitive or learning challenges. In addition, as many referrals come from healthcare providers, individuals without regular access to providers may be less likely to learn about ICBT. Importantly, these barriers mirror access issues seen in face-to-face therapy, highlighting the need for broader system-level solutions to improve equity in care.

To help address these challenges, we have established several patient-oriented working groups that include individuals with lived experience. These working groups inform our research priorities and shape the content, design and delivery of our services, helping to ensure that our service is relevant, inclusive and responsive to the needs of diverse populations (e.g., Hadjistavropoulos et al. 2025; Sapkota et al. 2023). For example, feedback from individuals with diverse cultural backgrounds has informed improvements to inclusive language, imagery and examples in course materials, and led to enhanced advertising to diverse groups (Sapkota et al. 2023).

Facilitators

The following reflections on ICBT implementation are organized using five key domains of implementation outlined in the Consolidated Framework for Implementation Research (CFIR; Damschroder et al. 2022). The reflections build on earlier CFIR-based research conducted by our team (Hadjistavropoulos et al. 2017).

Intervention characteristics

As described earlier, the OTU programs are grounded in robust evidence and have been demonstrated to be effective, acceptable and credible to clients. These characteristics strengthen the stakeholder confidence in the OTU and have facilitated the successful adoption of ICBT in Saskatchewan. The unit's ability to address a wide range of mental health concerns has further solidified its role in the province. Also supporting implementation is the fact that the OTU programs are both adaptable and trialable, allowing for modifications based on the clients' needs, followed by piloting to assess the effectiveness of changes and the need for further refinements. Implementation has also been facilitated by a strong focus on simplifying the client experience and enhancing program design. For example, we offer a user-friendly website, provide proactive phone support when clients encounter challenges, offer diverse treatment materials to accommodate different learning styles and offer some flexibility in the level of therapist support based on both client needs and preferences.

Outer setting

Persistent unmet need for timely, evidence-based and accessible mental health care has also created favourable conditions for ICBT adoption in Saskatchewan. Stable funding from the government to the unit for over a decade has acted as a facilitator for implementation. The inclusion of digital mental health in Saskatchewan's Mental Health Action Plan (Government of Saskatchewan 2023) means that the OTU is assisting the

government in addressing its mandate. Importantly, ICBT has been well-received by referring providers, particularly as it offers a solution for clients on waiting lists and those with limited access to face-to-face treatment. These facilitators reflect several key conditions identified in international guidance for implementing digital mental health services (Titov et al. 2025), including stable government funding, health system integration and provider endorsement.

Inner setting

The OTU benefits from being housed within a dedicated and specialized unit at the University of Regina without competing demands for face-to-face service delivery. This has enabled access to an information technology team that has developed and continues to refine the OTU digital platform. It also provides access to institutional supports within the university for financial and human resource management, as well as research administration (including research ethics review and support with drafting and reviewing funding agreements). The unit has invested in workflow design both internally and in coordination with the provincial healthcare system. Over the past 15 years, we have established strong networks and communication pathways that support operations and foster alignment with the broader healthcare delivery system. Guidance is provided through a management advisory group, which includes managers from Mental Health and Addictions in the Saskatchewan Health Authority, and a community advisory group, which includes managers from primary care, community-based organizations and community members who advise on linkages and contribute to communication with providers and programs. In addition, the OTU actively engages with healthcare providers and the public, distributing informational materials to physicians and other professionals, attending provider conferences and, at clients' request, sending progress letters to physicians and other care providers. The OTU is also integrated into provincial referral pathways: Saskatchewan's 811 HealthLine refers clients to our services and websites such as Saskatchewan.ca, Virtual Mental Health and Addiction Services and 211 Saskatchewan list the OTU as a freely available mental health service. Collectively, these efforts ensure that the OTU is embedded within mental health care in Saskatchewan and enhances accessibility, coordination and continuity of care.

Characteristics of the individuals

The work of the OTU has been accelerated by engagement with highly committed clinicians, researchers, trainees, client partners, decision-makers and international collaborators who believe in and value ICBT. The diverse network of stakeholders contributes expertise, accelerates innovation and champions implementation. Trainees play a particularly key role in expanding the understanding and development of ICBT.

Implementation process

The OTU follows a learning health system approach, embedding research within clinical care. Regular collection of outcomes and feedback from clients results in iterative refinement of content, therapist practices and operational procedures, which in turn ensures that the service is responsive, evidence-based and aligned with evolving client, therapist and system needs.

Challenges

The CFIR (Damschroder et al. 2022) can also be used to reflect on challenges with the OTU's model of ICBT implementation. Most challenges listed here represent potential risks rather than current limitations.

Intervention characteristics

Existing ICBT programs offered by the OTU are designed for adults, delivered in English and rely heavily on text-based content. This poses access barriers for youth, non-English speakers and individuals with lower literacy levels. As technology evolves, there are suggestions from clients to incorporate advancements within the OTU platform, including features such as translation tools, expanded video and audio content, chatbots, mobile-based homework and gamification. While these features create opportunities to enhance the accessibility and engagement with ICBT for underserved groups, they are costly to develop and present challenges when integrating them into an established platform.

Outer setting

While public awareness of ICBT is growing, feedback from stakeholders suggests that some confusion exists about how ICBT differs from other digital mental health options, such as mobile apps or telehealth. Many users are unaware of the evidence base or features of ICBT. Targeted strategies are needed to increase awareness among potential users and referring providers. Looking ahead, the Mental Health Commission of Canada has introduced a national assessment framework for mental health apps, and there could be growing pressure for programs such as the OTU to undergo formal review. In addition, there may be expectations to integrate the platform in broader digital ecosystems, such as provincial electronic health records, which could present logistical and technical challenges. Although OTU client records are not currently integrated into the provincial system, the OTU platform securely collects and retains standardized outcome measures collected before, during and post treatment. These outcomes are shared with the clients, who may request that results be sent to their providers for coordination of care and inclusion on the electronic health record. Although this approach does not create a complete health record, it offers clients flexibility in determining what information is shared

and documented in their file. This client-directed approach balances the benefits of autonomy and privacy with the limitations of not creating a fully integrated health record.

Inner setting

At present, the OTU has sufficient infrastructure and staffing to meet the client demand. However, rising demand requires ongoing monitoring to ensure not only capacity for service delivery, but also training and supervision and maintenance of a healthy work culture.

Characteristics of individuals

Future service expansion may require onboarding of new team members, which presents opportunities but also risks to preserving the quality of service and the collaborative culture that has supported successful implementation to date.

Implementation

Embedding research into service delivery fosters ICBT refinement but also requires careful coordination to balance and coordinate research activities and practice. As technological enhancements are introduced, it will be important to continue to balance scientifically rigorous research while ensuring clients' needs remain central.

Conclusion

Over the past 15 years, the OTU has demonstrated that ICBT is an effective way to offer another pathway to receive mental healthcare. By continually evolving our services – from disorder-specific to transdiagnostic and population-tailored courses – and by integrating research into service delivery, we have been able to meet the needs of diverse client groups. Our primarily text-based, therapist-guided model offers clients privacy, autonomy and accessibility, while maintaining strong clinical outcomes and high satisfaction. Looking ahead, assuming ongoing government funding and alignment with provincial strategic directions, the OTU will remain housed within the university for the foreseeable future, as there continues to be a need for dedicated resources to support the development and evaluation of new courses and to respond to technological changes. As we continue to expand and refine our offerings in Saskatchewan, we remain committed to increasing the reach of ICBT, ensuring that more individuals receive timely, evidence-based support for their mental health.

In terms of national collaboration, while therapist-guided ICBT has not been extended outside of Saskatchewan, given funding and therapist registration requirements, the Alcohol Change Course has been made available nationwide in a self-guided format based on our past evidence that clients can benefit from this approach (representing ~40% of clients enrolled). We have also shared findings widely with organizations across Canada to inform initiatives in other provinces to develop and deliver ICBT. In addition, over the past five years, the first author has led the development and rollout of an ICBT program for public safety personnel (www.pspnet.ca), now available in a self-guided format to all Canadian public safety personnel and in a therapist-guided format in several provinces. This expansion to public safety personnel has been a response to Canada's Action Plan on post-traumatic stress injuries and required both national and provincial funding, stakeholder interest, bilingual service delivery and therapists registered in multiple provinces. Expansion of the OTU model to other jurisdictions or targeted groups would similarly require stable, multi-year funding, a clear governance structure, partnership agreements, provider registration in other provinces and integration within existing care pathways. The OTU exemplifies a strong, scalable model that integrates clinical service and research to improve evidence-based mental health care access and enhance outcomes across populations. HQ

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