

Addressing the Access Gap: Leveraging the Potential of E-Mental Health in Canada

Summary Report

Prepared by
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*Mental Health Commission of Canada Roundtable
Addressing the Access Gap: Leveraging the Potential of e-Mental Health in Canada*

Friday, January 27, 2017
University of British Columbia
Vancouver, B.C.

Mental Health Commission of Canada

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Executive Summary

Mental Health Commission of Canada Roundtable Addressing the Access Gap: Leveraging the Potential of e-Mental health in Canada

Friday, January 27, 2017

University of British Columbia, Vancouver, B.C.

Canada faces a “crisis of access” when it comes to mental health services, in part because as stigma recedes more people are seeking care. E-Mental health could play an important role in breaking up this logjam by extending reach, spawning additional access points and promoting higher quality care.

To explore how e-Mental health technologies can be leveraged, the Mental Health Commission of Canada (MHCC) hosted a roundtable meeting in Vancouver on January 27, 2017. Policy makers, organizational leaders, people with lived experience and researchers from across Canada, along with a panel of international experts, came together to:

- increase awareness of the latest evidence on the effectiveness/efficacy of e-health solutions in improving access to mental health care.
- identify and examine existing models of e-Mental health that have been implemented in Canada and internationally.
- identify and discuss barriers and facilitators to the adoption and implementation of e-Mental health approaches to improve access to services.
- explore recommendations to support the development, implementation and evaluation of current and/or future opportunities in e-Mental health.

In her keynote address, Dr. Lori Wozney of the Centre for Research in Family Health, focused on the state of e-Mental health in Canada.

She and her colleagues have found there is a strong appetite for e-Mental health solutions—even if there is not always clarity about what constitutes e-Mental health—and that perhaps one of the greatest barriers to adoption is a risk-averse decision-making culture.

The morning panel looked at e-Mental health models that have been implemented in Canada. Dr. Peter Cornish, an associate professor and director of the Student Wellness and Counselling Centre at the Memorial University of Newfoundland, showcased Stepped Care 2.0. This integrated primary care model blends a heuristic for organizing programs with e-Mental health solutions for monitoring patient progress and delivering care. Dr. Heather Hadjistavropoulos of the University of Regina discussed her work with the Online Therapy Unit for Service, Education and Research (Online Therapy USER), a service offering free Internet-delivered, cognitive behavioural therapy to adults.

Following a lunch and networking break, MHCC President and CEO Louise Bradley opened the afternoon session with brief remarks on her vision for e-Mental health in Canada, emphasizing the necessity of cooperation in order to move forward and address the access crisis.

The second panel featured experts from New Zealand and Australia, who talked about the e-Mental health experience in their countries. Andrew Slater, CEO of Homecare Medical, described taking on the challenge of managing New Zealand’s country-wide digital health care platform, while HealthTRx CEO Anil Thapliyal reviewed e-Mental health success factors, including a centralized approach and sustainable budgeting.

Young and Well Cooperative Research Centre founder and CEO Jane Burns described the revamping of Australia's mental health care system to incorporate technology and patient-led care. Ian Hickie, co-director of the University of Sydney's Brain and Mind Centre, followed with his take on how to effect system change.

During the three breakout sessions, participants worked through a series of questions on conceiving and advancing e-Mental health solutions in Canada. The ensuing discussions touched on a wide range of ideas and issues related to e-Mental health. Common themes included the need to bridge the digital divide, the challenge of bringing e-Mental health

to rural communities, the need to overcome risk aversion to drive innovation, the value of person-led care and the possibility of applying promising solutions to like settings.

The meeting concluded with the MHCC stating its intention to disseminate the findings of its e-Mental health roundtable series via the MHCC website. Before departing, participants submitted their next steps, which included sharing new knowledge with colleagues, following-up with select presenters and participants, engaging key stakeholders, evaluating existing e-Mental health solutions and taking steps toward implementation.

Key Takeaways

The following emerged from the roundtable as clear principles for future action on e-Mental health:

- **Person-led is the way forward.** This is important both in partnering with users who will be using the services in order to design them and in giving people control over their own data.
- **The digital divide must be addressed.** Those unable to access the requisite technology and services—or who lack the skills or knowledge needed to take advantage of e-Mental health solutions—will be left out.
- **E-Mental health is integral to improving access.** While there are no “magic bullets”, e-Mental health solutions provide the opportunity to increase access to services and help relieve Canada’s overburdened mental health care system.
- **Innovation requires some tolerance for risk.** Evidence of effectiveness is important to guiding mental health system decisions, but traditional methods of evidence-gathering can be too slow or inexact for e-Mental health. A model more suited to technological solutions should be used, such as one that generates data through continuous quality improvement or ongoing program evaluations.
- **We need coordination.** There is a desire to proliferate e-Mental health solutions, but nothing will get done without a coordinated effort. Teamwork, partnerships and formalized strategies for e-Mental health are essential.
- **Strong leadership is key.** E-Mental health needs champions among practitioners, government and people with lived experience. Inspiring people to take up the cause requires increasing the visibility of e-Mental health and the evidence supporting it.
- **Tech is borderless; collaboration should be, too.** We need to look globally to see what works—and share our information internationally.
- **Ultimately, it is about system change.** Rather than an add-on to the status quo, e-Mental health is and should be seen as an enabler of system change.

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“We need to grab everything we can, learn about what we can do, and do it better, and share our good stuff with other countries and other providers.”

Dr. Michael Krausz

Introduction

The growing number of Canadians seeking help for mental health problems has created a systemic logjam. Mental health care providers are overburdened, with patients facing wait times of sometimes over a year. Many system stakeholders see e-Mental health as the key to positive change, with its potential to extend reach, spawn additional access points and promote higher quality care.

The Mental Health Commission of Canada (MHCC) first brought together stakeholders to explore e-Mental health in 2012. That led to the publication two years later of *E-Mental Health in Canada: Transforming the Mental Health System Using Technology*—a briefing document on technology’s potential to transform the delivery of mental health services, with acknowledgement of some the barriers to implementation. It concluded with nine recommendations to inform the development and spread of e-Mental health across the country. The MHCC also recommended expanding e-Mental health in *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*.

With a renewed focus on e-Mental health, the MHCC is undertaking research and knowledge exchange activities to inform the development of a plan for driving e-Mental health. This includes hosting a new series

of roundtables to give key stakeholders and decision makers a forum for discussing e-Mental health in Canada.

The first roundtable in Ottawa in December 2016 brought together health care leaders and frontline mental health practitioners from hospitals, community settings, regional health authorities and national associations across the country to discuss e-Mental health.

The second, held in Vancouver in January 2017, engaged policy makers, organizational leaders, people with lived experience and researchers in discussions of how e-Mental health can be used to improve access. Along with representatives from Canada’s provinces and territories, the meeting featured international experts from New Zealand and Australia, who shared how their countries have approached e-Mental health.

E-MENTAL HEALTH MEANS...

“...mental health services and information delivered or enhanced through the Internet and related technologies.”

While there is no universal definition for e-Mental health, the MHCC adopted the above quote from Christensen, Griffiths and Evans because it is broad enough to account for the constant evolution of technology.

* Christensen, H., Griffiths, K., & Evans, K. (2002). E-Mental Health in Australia: Implications of the Internet and Related Technologies for Policy. ISC Discussion Paper No 3, Commonwealth Department of Health and Ageing, Canberra.

The goals of this roundtable, which built on the goals of the first, were to:

- increase awareness of the latest evidence on the effectiveness/efficacy of e-health solutions in improving access to mental health care.
- identify and examine existing models of e-Mental health that have been implemented in Canada and internationally.
- identify and discuss barriers to and facilitators of adoption and implementation of e-Mental health approaches.
- explore recommendations to support the development, implementation and evaluation of current and/or future opportunities in e-Mental health.

This report summarizes the proceedings for attendees and other interested stakeholders who inform, design or deliver mental health services. It provides a general reflection of the roundtable and is not intended to represent the perspective of any one individual or organization.

Welcome and Opening Remarks

The MHCC is currently working to advance e-Mental health by focusing on three key areas: research, knowledge exchange and partnerships. This roundtable was the second delivered as part of this year's knowledge exchange activities.

Haida Elder Woody Morrison, who is from Hydaburg, Alaska, opened the session with a prayer to acknowledge the unceded territories of the Coast Salish peoples where the roundtable was held.

Nicholas Watters then set the context for the event, introducing the MHCC and the intent of the roundtable to foster authentic discussion. He acknowledged the range of participants—representatives from nearly every province and territory, as well as international experts, and the diversity of perspectives.

PRESENTERS

Elder Woody Morrison
Family Support Elder, Vancouver Aboriginal
Child and Family Services Society

Nicholas Watters
Director, Knowledge Exchange Centre, Mental
Health Commission of Canada

*“Realistically, not everything is going to work:
failure is part of design and learning.”*

Dr. Lori Wozney

The E-Mental Health Landscape in Canada: What We Know, What We Don't and What We're Finding Out

As part of a research team led by Dr. Patrick McGrath, Dr. Lori Wozney has found a strong appetite in Canada for e-Mental health solutions—even if there is not always clarity about what constitutes “e-Mental health”. According to Wozney, perhaps one of the greatest barriers to adoption is a risk-averse decision-making culture.

Catching up on e-Mental health in Canada

The last general scan of e-Mental health in this country was published in 2014. Wozney is on a research team updating that work, conducting an extensive literature review that spans everything from Internet-based PTSD interventions to mobile apps for managing depression.

As part of that effort, she and her colleagues interviewed nine clinician/researchers and 11 mental health system administrators to produce a high-level summary of current and proposed initiatives, implementation challenges, resources and opportunities in e-Mental health. Wozney presented the findings of those interviews to give context to the day's discussions, following the RE-AIM framework:

Reach—Are technologies getting to the people they are supposed to, and with what degree of uptake?

Effectiveness—How is “success” defined?

Adoption—What do organizations need in terms of capacity, training, skills, etc., to adopt e-Mental health technologies?

Implementation—What resources are needed to move research into practice?

Maintenance—How can e-Mental health technologies be sustained and made part of the standard system?

Reach

Wozney said there is high demand for e-Mental health solutions, though what that means is not necessarily consistent, e.g. in one case “e-Mental health” might be a text-message appointment reminder, while in another it is a fully online self-managed application. Even “demand” can mean different things in different situations. For some communities, it may be a desire to enhance an existing toolkit of resources, while for others it is the more fundamental drive to provide access to basic services.

PRESENTER

Dr. Lori Wozney

Research Associate, Centre for Research in Family Health

Wozney noted that most e-Mental health solutions today focus on mild-to-moderate cases of anxiety and depression with less management risk. Although youth may be more connected than older people, that does not always mean young people will adopt e-interventions, begging the question of whether the perceived generation gap is in fact a skill gap.

Effectiveness

All those surveyed by Wozney and her colleagues said they wanted better health outcomes from the use of e-Mental health technologies. The majority (65 per cent) also said they wanted to understand usage, and to have some way of gauging whether or not people like certain technologies. Many felt there is little available evidence of uptake.

Even more respondents (75 per cent) wanted to see metrics at the system level. Do certain interventions translate into fewer emergency room visits or better school interactions? How is the system changing with the integration of e-Mental health tools? Wozney noted

researchers need to look specifically at how to track these kinds of measures in order to “move the needle forward.”

Adoption

All survey respondents knew of at least one e-Mental health solution, with telepsychiatry the most commonly cited. They had fragmentary awareness of e-Mental health activity across Canada, and suggested Canada needs an overarching national strategy for e-Mental health.

On the challenges of implementation, Wozney gave the examples of Kids Help Phone, which introduced text-based services but did not initially have training resources to support the rollout, and of nurses at Dalhousie who did not know if or how they should connect with patients via social media.

“Even if you know the mechanisms and clinical content, you need to understand how technology changes what you do,” she said.

Wozney said respondents felt regulation needs to become less conservative, and that issues of privacy and security perceived as roadblocks often have readymade solutions. Good policy documents are required to help clinicians understand what is within their scope of practice.

As well, it was felt organizations need to become less risk averse to traverse the “death valleys” between basic biomedical research and clinical science, and between clinical science and practice. While academics have a good sense of evidence, administrators do not always know what data to believe or where it is. Implementation science is a required area of study.

Implementation

Confidence in dealing with risk carries over to implementation. Realistically, not everything is going to work: failure is part of design and learning. Today, overcoming the fear of risk typically requires a clinician to champion a particular solution and bring others on board. Going forward, strong leadership will continue to be important.

Interviewees also said continuous investments in technology infrastructure are needed to break organizations free from the current, unsustainable approach of applying for successively larger grants without certainty of getting them.

Partnership will remain important, especially with industry. As Wozney pointed out, people can order pizza online, but cannot get surgery reminders over the same channels. A key question for respondents is how partnerships alter organizations’ values and rights to intellectual property, given the current lack of legal guidance. Many wondered where they most needed to work with industry and what that might look like.

Maintenance

Maintenance requires an understanding of metrics, of what should be reported over what period of time, and what, comparatively, would be the cost of doing nothing. Long-term analyses have to account for cost, but simply comparing the direct costs of face-to-face interventions versus online may be simplistic and not tell the whole story. Ultimately, research funding, sponsorship, partnership and industry involvement are all needed to make sure good ideas do not “die on the vine.”

Q&A Highlights

How far back will your systematic review go?

Wozney said her update will look back to about 2010 and will include grey literature and program evaluations across all clinical areas, qualitative studies and pilots. She invited the group to suggest any studies for inclusion.

How does one organize one's practice to integrate technology into care?

Wozney said she and her team have done work on workflow. The people they spoke to said one problem with technology is that organizations keep

adding solutions without taking others away. Wozney's report will look at what is happening with workflow and what needs to change.

Are you looking at organizational or institutional barriers to translating research into practice?

This was not part of Wozney's RE-AIM work, but the review will look at what is successful or not. Organizational research is "not great today", in Wozney's words, and there is not a lot of implementation research, meaning it is not even clear which metrics should be looked for.

Is all your research focused on clinicians? What about people with lived experience?

Wozney said pilots and usability studies typically include end users, but acknowledged the lack of user perspective is "a huge problem." Researchers build programs based on what they think is needed. Metrics around usage and satisfaction are either not fleshed out or are very high-level. She said she is including self-help apps in her literature review, but these were not necessarily part of the key informant interviews.

Canada is a country of pilot projects and long-term consultations. Addressing e-Mental health and web-based resources should be international in order to avoid that.

Wozney agreed, and said her literature review will be international. Beyond their MHCC-commissioned research, she and her colleagues have done key informant interviews with 75 people and are pulling in good material.

The MHCC intends to disseminate the literature review and environmental scan widely in Spring 2017.

*“Finally, people are interested in mental health
and everyone is running to get in the door.
But we only have one door, and there’s a long
lineup. We need multiple doors.”*

Dr. Peter Cornish, Memorial University

The Canadian Experience: Promising Practices

The morning presenters showcased two e-Mental health models that have been implemented in Canada. Dr. Peter Cornish spoke about Stepped Care 2.0, an integrated primary care model that blends a progressive model for organizing programs with e-Mental health solutions for monitoring patient progress and delivering care. Dr. Heather Hadjistavropoulos discussed her work with Online Therapy Unit, a service offering free Internet-delivered cognitive behavioural therapy to adults.

Tackling wait times with the stepped care model

Reduced stigma around mental illness and mental health problems has encouraged more people to seek help from specialists. As a result, wait times have skyrocketed, resulting in a “crisis of access”. According to Cornish, the stepped care model has great potential to address that crisis, noting that at Memorial University of Newfoundland in St. John’s, Nfld., and George Washington University in Washington, D.C., stepped-care pilots abolished waiting lists overnight.

Part of the reason services become overburdened is due to what Cornish called a “mental health literacy problem.” Many referrals to mental health professionals are “false positives”, i.e., they involve patients who are not technically mentally ill, but who want to improve their mental health.

Stepped-care shifts the burden of treating such patients away from specialists to primary care, assisted online self-help or online peer support, which may be better suited for coaching people

through mental health problems. This frees up specialists to treat patients with mental illness. It also aims to maximize patient autonomy and self-advocacy to foster the self-help skills and resilience needed to overcome the struggles that are part of life.

“We need to teach resilience,” Cornish advised. “Our society is passing the hot potato, saying, ‘You need professional care.’ That’s not a good message. We need to empower people to take care of their own mental health.”

The stepped-care heuristic presents patients with the most effective and least resource-intensive resources first. These can be administered in a clinic or community setting, and may include e-Mental health apps or online self-help services, as well as “behaviour prescriptions”, e.g. directing patients to volunteer for therapeutic benefit. In the scenario Cornish presented, providers monitor patient progress with the Behavioral Health Measure-20, an electronic 20-question survey. If a person is not responding to treatment, he or she is escalated to the next level of care.

PANELISTS

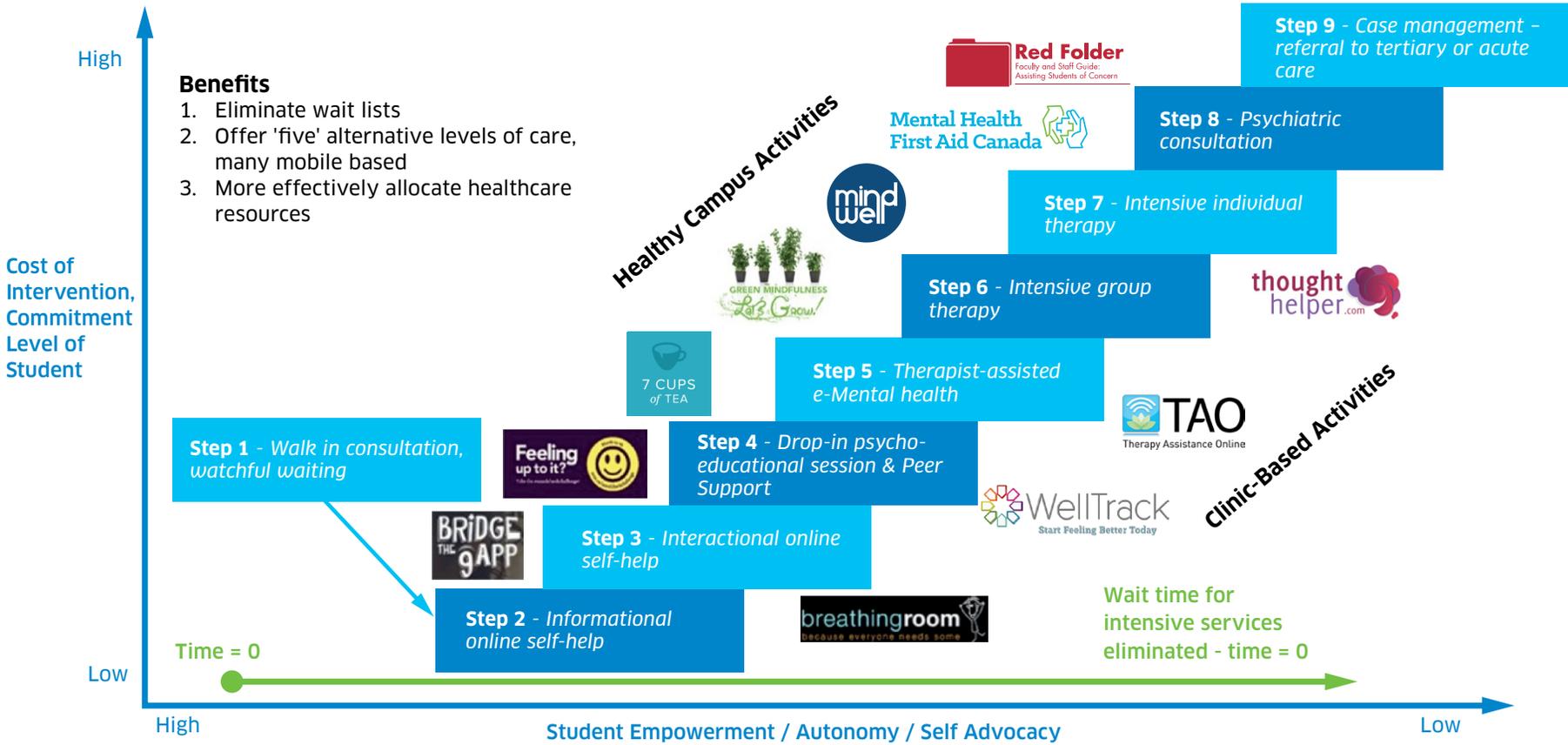
Dr. Peter Cornish

Associate Professor and Director,
Student Wellness and Counselling Centre,
Memorial University

Dr. Heather Hadjistavropoulos

Professor of Psychology, University of
Regina;
Principal Investigator, Online Therapy USER,
Saskatchewan

Stepped Care 2.0 for Mental Health



Graphic: courtesy of Dr. Peter Cornish

In all, there are nine steps in the model—from initial consultation or single-therapy session, to online self-help resources and coaching, to intensive therapy and psychiatric consultation, ending at system navigation (where providers connect patients with suitable resources)

or tertiary referral. Cornish noted that his team is working on developing a technology platform that will show providers where patients are in the system, which should enable them to think and act more systematically. This view could be available to patients as well.

Cornish gave evidence that stepped care has increased caseload capacity by more than 15 per cent while maintaining prior high levels of service user satisfaction. Other evidence suggested 15 minutes of practitioner time per week in the stepped-care context could have the same or greater impact on patient well-being, anxiety, depression and life functioning as an hour of traditional face-to-face therapy.

Serving up online therapy in Saskatchewan

Operating out of the University of Regina, the Online Therapy Unit for Service, Education, and Research draws on an Australian model for online therapy (mindspot.org.au). Dr. Heather Hadjistavropoulos explained the program started in four clinics and gradually increased in scope, with nine of the 12 Saskatchewan community mental health clinics involved.

Clients visit onlinetherapyuser.ca to access the service. There they can watch an introductory video and complete an online screening process, followed by a phone screening. Hadjistavropoulos noted that about 50 per cent of users are referred by physicians.

Clients that prove a good fit after screening receive a username and password to access Internet-delivered cognitive behavioural therapy (iCBT) materials, which they are to review on a weekly basis. New clients are also assigned to a trained therapist who they work with via secure online messaging or phone calls lasting 15 to 20 minutes. The service focuses on treating depression, anxiety and panic disorder, but does offer transdiagnostic programming. The typical program currently involves five modules over eight weeks.

From November 2010 to December 2016, the unit screened 2,400 people and took 1,700 into its services. The remainder were either referred to a mental health clinic or fell out of contact. Clients are based in both urban and rural areas (49 per cent in the latter case). For about a quarter

(26 per cent), the service was their first experience of accessing mental health care; 13 per cent said they were using it while waiting for other care.

Hadjistavropoulos countered the perception that the service handles only mild to moderate cases. A full 48 per cent of clients have exhibited severe symptoms associated with depression or anxiety, with three per cent and 16 per cent showing minimal or mild symptoms, respectively.

The service maintains a high client satisfaction rate, with 91 per cent of users satisfied or very satisfied with the quality of treatment, 95 per cent feeling the course was worth their time, and 95 per cent also saying they would recommend it to a friend. Completion rates and impact are also favourable, with 80 per cent finishing the program and large effect sizes similar to those associated with face-to-face therapy.

Hadjistavropoulos emphasized that achieving these results was not easy, and required strong leadership and the engagement of diverse stakeholders. There was a lot to learn about developing a service and much to consider in terms of what the website would look like, how to screen clients, and other policies and procedures. Some clinicians have bought in more readily than others, although this has improved generally over time. She said the sentiment that this type of service is not on par with face-to-face therapy has changed, but there is still some pushback.

She ended her presentation by looking at the road ahead and future goals for the Online Therapy Unit, which include ramping up engagement, rolling out additional programs, improving the website and securing a research grant for personalized iCBT delivery (for tailoring the duration and nature of treatment to patients' needs and preferences).

Q&A Highlights

What is the average number of patients per clinician through the Online Therapy Unit?

Hadjistavropoulos said that in addition to their face-to-face caseloads, clinicians typically work with six clients at a time through the online unit, requiring a couple of hours per week. Therapists employed directly by the Online Therapy Unit typically work with 20 clients per day.

Do you have any insights around change management?

Cornish said providers need convincing. While funders, administrators and patients like the stepped model, about a quarter of providers are resistant, arguing that this kind of service, 'Isn't what they signed up for'. They believe it cheapens the health care system and that the correct response to the access crisis is to add more people. Cornish argued that training is needed and monitoring tools to be used therapeutically. Hadjistavropoulos answered that change has been a continuous process, starting with one day of training for clinicians, followed by supervision.

How do you manage comorbidity?

This question spurred the Online Therapy Unit's move to a transdiagnostic program, as it is better suited to helping people with multiple problems. Hadjistavropoulos noted that previously clients had to be moved from one program to another. The service is also developing a "booster course" that clients can take after a year to refresh their knowledge, which could further help with comorbidity. Cornish said the stepped-care model could be applied to all sorts of conditions.

How are providers paid?

The Online Therapy Unit is completely government-funded, and clients are not charged. The community mental health clinics have providers designated as iCBT providers, who are paid out of the public purse. Cornish said the stepped-care program at Memorial University is publicly funded and is not very expensive, apart from program licensing.

How open is the stepped-care model to incorporating other systems users may want to use?

The model is not tied to any one provider, but rather it just maps where patients are. Cornish said the aim is to be patient-centric by giving patients the power to access any of the services they want.

E-Mental Health: A Game-changing Approach

“We want to put an end to our reputation as a land of pilot projects and move forward in a definitive way.”

Louise Bradley

MHCC President and CEO Louise Bradley opened the afternoon session with brief remarks. Considering her vision for e-Mental health in Canada, she said, “I think it’s sitting right here in front of me—all of you being together here, across Canada and internationally.” She emphasized the need to work together to resolve what Cornish had called the current “crisis of access”, and reiterated the MHCC’s commitment to moving e-Mental health forward, highlighting models such as those being discussed at this roundtable. She concluded by thanking the MHCC staff for coordinating the event and all those in attendance for their participation.

PRESENTER

Louise Bradley
President and CEO, Mental Health Commission
of Canada

Lessons from Abroad

The afternoon panel brought international perspective to the day's discussions. New Zealand's Andrew Slater and Anil Thapliyal talked about their country's integration of online and telehealth services into a single service platform and key factors for successful e-Mental health rollouts. Jane Burns and Ian Hickie described how Australia has transformed its mental health system to include technology and patient-led care—and made a case for getting beyond status quo thinking.

New Zealand

From helplines to online

The roots of New Zealand's e-Mental health system stretch back to the rollout of telephone helplines in the 1950s. By the second decade of the 2000s, the country had more than 100 health and social services helplines along with a growing array of virtual services. To save costs, the government decided to centralize the management of those disparate offerings within a single national telehealth service. Slater's organization, Homecare Medical, was one of the bidders to run it.

The challenge, Slater explained, was that Homecare Medical was a company of two people at the time. After winning the two-year procurement competition, he and his business partner had 15 weeks to hire 300 people, conduct 7,000 hours of training, build four contact centres, a software system and a secure, cloud-based health platform.

The company did it by partnering—ensuring the expertise of industry, government, service

users and other stakeholders was harnessed to meet user needs. Slater said that spirit of collaboration was informed by a set of core values: quality, doing the right thing, maintaining a passion for “better”, and the Maori concept of *pokohiwi ki pokohiwi*, doing things side-by-side.

One of Homecare Medical's key commitments was to make sure virtual care did not become another, separate “system”, but rather something that would strengthen the existing system with more capacity and tools. Five teams were organized to deliver virtual services 24/7: health advisors, mental health and addictions specialists, nurses, poisons officers and emergency triage nurses, with plans to add mental health nurses in 2017. In the first month, the national telehealth service had contact with over 1 million people.

To ensure its ongoing ability to bring “great digital health experiences to Kiwis”, the service has an innovation fund built in. Every dollar of revenue generated goes into the fund at year-end for further investment. At the end of

PANELISTS

Andrew Slater

CEO, Homecare Medical, New Zealand

Anil Thapliyal

CEO, HealthTRx, New Zealand

Jane Burns

Founder and CEO of the Young and Well Cooperative Research Centre, Australia

Ian Hickie

Co-Director, Brain and Mind Centre, University of Sydney

the 10-year contract, unless it is renewed, all leftover funds will go to the government.

Slater said the service aims to make full use of tools that are relatively low-cost and consume fewer clinical resources, e.g. public information campaigns and personalized automated advisory services. This helps reserve clinically rich and more expensive services, such as phone and video consultations and face-to-face interventions, for those in greatest need. He and his colleagues are committed to ensuring “every door is the right door.”

In summary, Slater itemized a handful of takeaways from the New Zealand experience:

- Partnerships are vital, and contractual terms should insist on them.
- Digital deprivation (i.e. the digital divide) must be overcome, potentially by working with telecommunications providers to have them donate technology.
- “Be bold but bounce from what you’ve got.” Think big, but build on existing foundations.
- Ensure clinical credibility.
- Disrupt from inside, i.e. work within the system, not against it.
- Be up front about how to address privacy issues, and do not let them be a barrier.
- Be accountable to the taxpayer.
- Contracts should be less specific, long-term and outcome-focused.

- Innovation funding is critical and organizations should be prepared to fail.
- Marketing and promotion are important first steps in digital delivery.

Finding better pathways

Thapliyal followed with his own reflections on success factors based on his involvement in e-Mental health and addictions in New Zealand.

He said definitions matter. New Zealand favours Helen Christensen’s “mental health services and information delivered or enhanced through the Internet and related technologies” with its four-part matrix of information provision, screening, social support and intervention (with a prerequisite of intervention being that it meets the requirements of secondary care).

He also said New Zealand is fairly “app rich”, considering its total area of 265,000 square kilometres and population of 4.5 million. From a policy standpoint, however, Australia is ahead of most of the world as it already has an e-Mental health strategy, although other countries, including Canada, are working toward formalizing their approaches.

One of the main questions that comes up for governments around e-Mental health is, “How do you buy this stuff?” How, for example, do Slater and his 300-person team get paid? When a very small service like New Zealand’s National Depression Initiative would have spent \$4.9 million a year on a two-seat call centre, how do you pay for the breadth of 24/7 services that the national telehealth service now provides?

New Zealand’s centralized approach has been key, along with sustainable budgeting that looks at how best to allocate resources across the supply chain. In e-Mental health, that supply chain includes creative agencies to develop social marketing campaigns, multi-channel helplines (web, email,

messaging and phone), personalized support services for interactive support and, ultimately, community agencies for face-to-face services.

Looking at the Canadian experience, Thapliyal said there are varying degrees of development across the country. He held up Newfoundland and Labrador as an example of a jurisdiction that has already worked in e-therapy alongside grassroots programs, mental health and addictions literacy, media, public relations and more.

Thapliyal echoed both Slater and Wozney from the morning session in saying organizations must be prepared to fail in order to innovate. Not every investment will succeed. He also said duplication of services and lack of coordination have to be addressed to maximize effectiveness and leverage investments for better outcomes.

Like Wozney, Thapliyal said implementation science is essential: involving service users in design and development, working from a strong evidence base, ensuring policy aligns with purchasing decisions and that mental health organizations partner with industry to develop and deploy solutions. Workflow alignment also matters. “When you add a lot to the system without taking anything away, you won’t have uptake,” he observed.

There is a perfect storm of conditions to move e-Mental health forward, Thapliyal concluded, with conversations underway like those started by the MHCC in 2012. He called for the creation of an e-Mental health Implementation Knowledge Nexus, an international collaborative that would take advantage of borderless digital technology. He called as well for greater partnership, the potential to develop a federal/provincial/territorial e-Mental health strategy for Canada, and for cohesive e-Mental health services across public health, primary care and secondary care, with due consideration of quality assurance.

Australia

Revamping mental health care in Australia

Australia’s mental health reform efforts are fundamentally changing how care is provided in the country. The shift, Jane Burns explained, is toward person-led care and co-design, where clinicians and service users work side-by-side to build a system that works.

One of the main drivers of this reform effort was a 2014 comprehensive review of Australian mental health programs and services that suggested the country’s system had major deficiencies and needed rethinking. Burns said the Government of Australia took that report very seriously, including its recommendation to use innovative technologies to improve access to services and support. There is also growing recognition that mental wellness is important for the country’s workplaces and economy.

Technologically, the reform effort is exploring use of the Internet of Things—highly distributed, interconnected, data-generating and data-sharing devices. These enable person-led self-management and immediate access to high-quality, person-centred support, while freeing clinicians’ availability for the highest-need and most complex cases. Burns acknowledged that service users want choice, e.g. getting treatment online or at a clinic. Facilitating that kind of choice has not previously been embraced by Australia’s health care system, but the reform effort is changing that.

Users are already reflecting some of these transformations in their own behaviour by using technologies like FitBits and mobile apps, or choosing to participate in online forums. Many seem to want to take ownership of their own health records, which would let them choose with whom they share their information.

Calling young people “the single most important asset we have”, Burns discussed her work on the Young and Well Cooperative Research Centre’s

Youth Brains Trust project, which she said “changed the way we think about research in Australia.” It brought youth together with researchers, practitioners and policy makers to explore how technology can improve young people’s lives. Youth acted as partners in research rather than patients or clients, marking a shift in program design. Burns mentioned they were able to take projects to scale quickly by adopting a “rapid R&D process”, which involved partnering with tech giants like Google, Facebook and Twitter.

She concluded by highlighting several e-Mental health technologies for youth. These included Synergy, an online platform that connects young people to mental health care professionals and integrates technologies such as FitBit, Jawbone Up and e-Mental Health Clinic, a web portal offering resources, progress tracking and an online clinical assessment tool that forwards results to a physician.

“Just because you have control of government purchasing doesn’t mean you have control of the system.”

Ian Hickie

Tapping into global talent

Following Burns’ remarks, Ian Hickie questioned the proposition that clinicians must be on board to advance e-Mental health. He argued that the “borderlessness” of technology essentially means if no one in a particular jurisdiction is interested in advancing change, someone else somewhere else will.

In Australia, mental health care reform has benefited from a prime minister who is invested in technology. He sees its potential to transform health and human services to be person-centric, cost-effective and accessible to the world. Hickie noted that whether that transformation originates in Australia is not a concern.

The goal is not to create one system, but a backend to meet purchasing power where it is. He ended his brief remarks with a question: How do we bring highly skilled clinicians together with technology’s opportunities?

Q&A Highlights

When you have a suite of options and so many different programs, what do you use as the evidence base?

Burns noted that with a backend R&D platform in place, it is possible to measure who has used which services, whether it was the right care and if no harm was done—building evidence based on service improvement rather than old models. Hickie said the key is having the technology infrastructure to support the connectivity to achieve desired outcomes (“The diagnosis doesn’t matter: the outcome does.”) Slater added that the new platform approach to managing e-services in New Zealand makes it easier to experiment without “project-izing” change. Thapliyal said in New Zealand the Ministry of Health picked up “Beating the Blues” even though it had not gone through clinical trials (although it has since in Canada). Ultimately, it is a question of leadership and willingness to take risks, balanced by clinical testing, but not dependent on it.

How did Australia overcome the barriers and enable truly person-centred care?

Burns explained she put together a “brain trust” and that each organization in Australia has a partnership group of people with lived

experience. There are also guidelines for user-focused design, and a rule for dedicating 10 per cent of the overall budget to person-led design. “It’s far more expensive to waste money on programs that don’t work,” she said. Hickie noted that within professional groups, user experience is still problematic. “The reason we have a national commission is because of the need for a stronger community voice.” Since people use technology in all parts of their lives every day, national organizations need to bring it continuously into every aspect of design. If people do not have a voice, the solutions will not get used.

How important is integration? Does all data have to reside in one place?

Slater said he and his organization work with practitioners and users to make sure the right information-sharing decisions are being made, and that people’s anonymity is protected when it has to be. Hickie said, “We’ve wasted billions on EHRs. The question is, ‘How do health systems behave and become part of the world people already live in?’” From the floor, Dr. Michael Krausz noted that Hickie was talking about the “underlying paradigm of healthcare governance”, and that while technology provides the tools, “We need to start to question the paradigms we’re working from.”

Breakout Sessions

One of the goals of the day was to give participants the opportunity to explore in a practical, hands-on way how they might apply some of the learning and principles discussed in their own jurisdictions. Participants were seated at tables with others from their regions. For additional perspective, national and international representatives were distributed among different tables. In some cases, where regional representation was high, more than one table represented a single region. In others, participants from multiple regions were clustered together. (See Appendix C for the full seating plan.)

Throughout the day, each table tackled six questions:

1. What are one or two specific opportunities for improving access to mental health services in your jurisdiction using e-Mental health solutions?
2. What innovative approaches could you adopt?
3. To implement your innovative approach, what barriers must you overcome?
4. What might facilitate implementation?
5. How can e-Mental health be integrated in the current system?
6. What would be the first steps toward implementation?

Several common themes emerged across all tables:

1. Innovation demands risk-taking.
2. Person-centred care is the goal; person-led care is vitally important.
3. The digital divide must be addressed or access issues will persist.
4. Related to the above point, until remote communities have the right infrastructure to support e-Mental health, other solutions to the crisis of access must be considered.
5. What constitutes “evidence” and how to gather it to inform decisions has to be re-thought for e-Mental health. Randomized control trials are not necessarily the best or fastest vehicle to prove effectiveness.
6. Promising solutions should be replicated across settings that have similar requirements.
7. Coordination and strong leadership are key to proliferating e-Mental health.

Discussions by table

Following is an account of each specific table group’s contribution to the overall conversation. In many cases, the groups used the suggested questions and presentations as starting points for their own explorations of top-of-mind issues. As a result, their comments and observations did not necessarily always directly correspond to the discussion guide.

British Columbia (A)

- Solutions that suit a university environment, such as the stepped-care model, could be introduced into primary in-patient care homes. There is also an opportunity to bring the stepped-care model to mental health care teams. Access points could include the places where people live, work and play, such as schools, businesses, primary care physicians' offices—anywhere people are in the right place.
- The digital divide is a serious problem as it bars people from accessing services due to skill and/or income. A national policy that supplies cell phones and Wi-Fi connectivity, or some other mechanism, needs to ensure equitable access.
- People with lived experience can act as effective e-Mental health champions, but need more awareness of e-Mental health solutions to do so.
- An important next step will be to find champions within the system and government, and to work on national policies that facilitate access and drive e-Mental health, and help bring people with lived experience on board.

British Columbia (B)

- Therapy-assisted online treatment could be linked to B.C.'s Bounce Back program framework.
- Universities in B.C. are ripe to replicate solutions that seem to be working, such as the stepped-care model.
- Technology should also be brought into high schools, as reaching pre-adolescents is a challenge, although how to do that is unclear.
- Making sure people are trained and knowledgeable is essential to integrating e-Mental health into the current system.
- Billing structures thwart innovation and system change. We may be able to think differently about service models by comparing them with what happens in other areas, e.g. industry.
- A coherent strategy is needed because out of that comes legislation and resources.
- Securing funding is a key next step.

Newfoundland and Labrador

- Updating legacy systems is difficult. It can take more than a decade to build an innovation into the system and many more years to undo something that is not working.
- Rather than create a single system that “does it all”, a more sustainable approach would be to get existing and future data stores to talk to each other and bring together information when needed.
- Giving patients control over their own data is important. To that end, a personal health record would be preferable over an electronic medical record. It is not the provider’s record, it is the patient’s. Why is the data held in a vault the patient cannot access?
- “Evidence-based” does not matter; “practice-based evidence” does. Whatever is tried can be monitored. The traditional model of clinical trials is often not appropriate when it comes to mental health care, as a lot of what is being tested is not pharmacological. We need to be less risk-averse to promote innovation.
- Silos within mental health funding are a barrier. Primary and secondary care “don’t talk to each other” because of those silos, which inhibit innovation.
- Strong leadership is key: “I’m going” versus “Come with me.” Making it happen. People may want to expand the stepped-care model beyond university settings, but it is not happening. The MHCC has a role to play here, as was done with *At Home/Chez Soi* project.

Ontario, Quebec and New Brunswick

- The evidence problem needs to be solved. At the health system level, we are not permitted to try things that are not supported by data. But how can we be innovative under this condition?
- A potential solution to pursue would be the creation of a national database that people could use to find services they need.

Alberta

- There are pockets of innovation, but no strategic approach to integrating and delivering. What is being done is being done adjunctively, rather than as actual treatment.
- There is a lot of variety in technology and the literature is robust, but we lack a way to tell if providers are using it.
- Internet-based cognitive behavioural therapy presents an opportunity to standardize care and expand reach with the existing workforce.
- A few specific questions stand out. How do you serve the needs of a client who is chronically ill? What different thinking must be brought to that? And will e-Mental health help seniors?

Manitoba

- Artificial intelligence, virtual reality technologies and gamification could be used in mental health care.
- Triageing could be improved by introducing a mechanism that speeds up and automates certain processes and eliminates the need to fill out forms.
- Randomized controlled trials are a hindrance when it comes to using tech to advance mental health care. By the time the necessary trials are concluded, technology will have changed completely and what was being examined may no longer be relevant.
- Social impact investing is another opportunity, e.g. paying on outcomes.
- Barriers to advancing e-Mental health include a risk-averse culture, lack of skills/ability to adapt to change and innovative approaches, lack of time, co-operation and fear of failure.
- While a “made in Manitoba” approach is appealing, we need to think more nationally and not continue duplicating effort.
- Key next steps include emboldening leadership, establishing an arm’s-length organization to drive e-Mental health forward, and tackling the risk challenge.

Nova Scotia and Prince Edward Island

- Collaboration and effective organization offer a better chance of effecting change through scale.
- We need to be agnostic when it comes to modality of care. The nature of the intervention is not important as long as it is right for the person. Organizing care around the individual is key.
- Maintenance costs are the bane of most large projects, so it is important to consider cost in dollars and people to maintain a high level of quality.
- Any e-Mental health program must be multi-channel–deliverable by phone, text, over the Internet, etc.

Nunavut and Yukon*

- Community readiness and capacity building are important. Multiple entry points are needed to ensure access. How do we apply Cornish's insights across vast jurisdictions such as Nunavut and rural communities?
- Certain e-Mental health solutions may currently be impractical for northern and rural communities. In Nunavut, inability to access services generally is a huge challenge. E-solutions won't help, given that broadband is slow, expensive and few households have home phones, let alone cell phones. However, there is an appetite for connected services, as patients enjoy using the telephone in health centres, for example, to call clinicians in other jurisdictions.
- Community supports should be owned and designed by the communities that use them.

* The roundtable did not have representation from Northwest Territories.

“E-Mental health is not about competition between face-to-face and other modalities. It is one of the most promising tools in the toolkit to give more people access to get the care and support they need.”

Dr. Michael Krausz

The Road Ahead: Final Remarks

Dr. Michael Krausz closed the day, calling the entire discussion around e-Mental health a discussion about the health care system. It is not about apps, phones or computers, but an opportunity to reconsider basic health care approaches from a patient-centred perspective rather than medical perspective.

What does that look like? Krausz outlined the five keys he took away from the day's proceedings:

- 1. User involvement.** Designing services that people need, with user involvement, is vital. Going forward, criteria for success might include peer recommendations of services, for example. Integrating professional services and peer-based platforms would allow people to “shop around” in a trusted environment for what meets their needs.
- 2. Implementation.** Implementation is a serious challenge that demands effective mechanisms. It is truly a science. Most projects fail because the implementation challenges are underestimated. Part of what is needed are funding mechanisms that support change and its implementation. Krausz posed a few questions on this. “What mechanisms would support better performance? Does responsibility for services need to be shifted?”

- 3. Business models.** Academic structures are slow and immobile. Australia provides strong examples of new business models. Collectively, we need to understand how to shift and combine different models, and develop new ones as mechanisms of change. Whatever is done, the outcome should be better mental health care and not simply, “Do it this way or that.”
- 4. R&D structures.** It is not just implementation that matters but R&D and implementation. R&D allows for adaptation and evaluation, for which strategies are needed. Randomized controlled trials are not invalid or obsolete. They work well for Internet-based cognitive-behavioural therapies, for example, but the methods need to be appropriate to what is being evaluated.

REMARKS

Dr. Michael Krausz

Providence Health Care B.C. Leadership Chair in Addiction Research;
Senior Scientist, Centre for Health Evaluation and Outcome Sciences (CHEOS)

- 5. Networking.** The main challenge, Krausz concluded, is that, “We are not serving the majority of the people we need to.” E-Mental health is not about competition between face-to-face and other modalities. It is one of the most promising tools in the toolkit to give more people access to get the care and support they need. The result will be a paradigm shift, and to realize it. “We need to grab everything we can learn about what we can do, and do it better, and share our good stuff with other countries and other providers.” Krausz emphasized the importance of establishing relationships and said he would love to see more people become part of the process of moving e-Mental health forward.

Conclusion and next steps

Nicholas Watters thanked all who attended for sharing their expertise and knowledge. He noted that the post-conference reports will be made available via the MHCC's website. The MHCC will also use insights gleaned from the roundtables to inform the development of e-Mental health products and tools to support decision makers. Before departing, participants submitted their intended next steps to the MHCC.

Commitments included:

- Share what was learned with colleagues.
- Use new knowledge to refine the case for implementing e-Mental health in the jurisdiction.
- Follow-up with select presenters and contacts made at the roundtable.
- Engage people with lived experience and other key stakeholders.
- Evaluate e-Mental health solutions, set up an action plan and engage those necessary for implementation.
- Learn about applications and tools to suggest to colleagues and future patients.

REMARKS

Nicholas Watters

Director, Knowledge Exchange Centre, Mental Health Commission of Canada

Appendix A: Meeting at a glance

9:00 a.m. – 3:45 p.m.

Item	Speaker
Opening	Elder Woody Morrison
Welcome and Introductory Remarks	Nicholas Watters , Director, Knowledge Exchange Centre, MHCC
The E-Mental Health Landscape in Canada: What We Know, What We Don't and What We're Finding Out	Dr. Lori Wozney , Research Associate, Centre for Research in Family Health
<i>Health break</i>	
The Canadian Experience: Promising Practices	Dr. Peter Cornish , Associate Professor and Director, Student Wellness and Counselling Centre, Memorial University Dr. Heather Hadjistavropoulos , Professor of Psychology, University of Regina; Principal Investigator, Online Therapy USER, Saskatchewan
Breakout 1: Identifying Opportunities	Facilitated by Ascribe Marketing Communications/MHCC
<i>Lunch and networking</i>	
E-Mental Health: A Game-Changing Approach	Louise Bradley , President and CEO, MHCC
Lessons from Abroad	Andrew Slater , CEO, Homecare Medical, New Zealand Anil Thapliyal , CEO, HealthTRX, New Zealand Jane Burns , Founder and CEO of the Young and Well Cooperative Research Centre, Australia Ian Hickie , Co-Director, Brain and Mind Centre, University of Sydney
Breakout 2: Barriers and Facilitators	Facilitated by Ascribe Marketing Communications/MHCC
<i>Health break</i>	
Breakout 3: Implementation	Facilitated by Ascribe Marketing Communications/MHCC
The Road Ahead: Final Remarks	Dr. Michael Krausz , Providence Health Care BC Leadership Chair in Addiction Research; Senior Scientist, Centre for Health Evaluation and Outcome Sciences (CHEOS)
Closing	Nicholas Watters , Director, Knowledge Exchange Centre, MHCC

Appendix B: List of participants

FIRST NAME	LAST NAME	TITLE	ORGANIZATION
Allison	Bichel	Senior Provincial Director	Alberta Health Services
Leanne	Boyd	Director, Policy, Research & Evaluation	Healthy Child Manitoba
Louise	Bradley	President and CEO	Mental Health Commission of Canada
Glenn	Brimacombe	CEO	Canadian Psychiatric Association
Darrell	Burnham	CEO	Coast Mental Health
Jane	Burns	Founder and CEO	Young and Well Cooperative Research Centre
Fiona	Choi	Postdoctoral Fellow	Department of Psychiatry, University of British Columbia
Karen	Cohen	CEO	Canadian Psychological Association
Fides	Coloma	Manager, Mental Health & Addictions Branch	Ontario Ministry of Health & Long Term Care
Connie	Coniglio	Provincial Executive Director	BC Mental Health & Substance Use Services
Peter	Cornish	Associate Professor & Director	Student Wellness and Counselling Centre, Memorial University of Newfoundland
Lisa	Crawley	Co-Chair	Canadian Alliance for Mental Illness and Mental Health
Sandra	Dawson	Advisory Council Member	Mental Health Commission of Canada
Rita	den Otter	Client Affairs Manager, BC	Canadian Institute for Health Information
Nathalie	Dumais	Présidente provinciale	Mouvement Santé mentale Québec
Marie	Fast	Clinical Manager, Mental Health Services	Department of Health and Social Services, Government of Yukon
Mark	Ferdinand	Manager, Corporate Strategy and Development	Canadian Foundation for Health Improvement
Heather	Hadjistavropoulos	Professor of Psychology	University of Regina
Eftyhia	Helis	Knowledge Mobilization Officer	Canadian Agency for Drugs and Technologies in Health
Ian	Hickie	Co-Director	Brain and Mind Centre, University of Sydney
Sam	Hodder	Director Mental Health, Northern Zone	Mental Health & Addictions, Nova Scotia Health Authority
Katie	Hughes	Senior Director, Operations	Canadian Mental Health Association - BC Division
Teresa	Jones-Dukes	Program and Policy Analyst	Healthy Child Manitoba
Kimberley	Korf-Uzan	Manager, Provincial Programs	BC Mental Health & Substance Use Services
Michael	Krausz	Program Director, Addictions Psychiatry	Department of Psychiatry, University of British Columbia
Lisa	Lachance	Executive Director	CYCC Network
Niki	Legge	Program and Policy Development Specialist	Government of Newfoundland and Labrador
Simran	Lehal	Former Youth Council Member	Mental Health Commission of Canada
Francine	Lemire	Executive Director and CEO	College of Family Physicians of Canada

FIRST NAME	LAST NAME	TITLE	ORGANIZATION
Elizabeth	Lychuk	Manager, Child and Adolescent Mental Health Programs and Mental Health Promotion	Northern Regional Health Authority, Manitoba
Victoria	Madsen	Territorial Director of Mental Health and Addictions	Government of Nunavut
Shelagh	Maloney	Vice President, Consumer Health, Communications and Evaluation Services	Canada Health Infoway
Sylvie	Martin	Director of Adult Services	Addiction and Mental Health Services, Government of New Brunswick
Hazel	Meredith	Executive Director	BC Schizophrenia Society Victoria
Woody	Morrison	Elder	Vancouver Aboriginal Child and Family Services Society
Mohammadali	Nikoo	PhD Candidate	University of British Columbia
MaryAnn	Notarianni	Manager, e-Mental Health	Mental Health Commission of Canada
Clare	O'Donnell	Policy Analyst	Mental Health and Substance Use Branch, BC Ministry of Health
Lynn	Pelletier	Vice President, Mental Health and Substance Use Services	BC Mental Health & Substance Use Services
Fred	Phelps	Executive Director	Canadian Association of Social Workers
Anthony	Phillips	Scientific Director	Canadian Institutes of Health Research, Institute of Neurosciences Mental Health and Addiction
Amy	Porath	Director, Research and Policy	Canadian Centre on Substance Abuse
Tracey	Preeper	Senior Advisor to the Minister	Nova Scotia Department of Health and Wellness
Catherine	Pryce	Senator	University of Calgary
Verna	Ryan	CAO, Mental Health and Addictions	Acute Care, Health PEI
Megan	Schellenberg	Program Manager, e-Mental Health	Mental Health Commission of Canada
Andrew	Slater	Chief Executive	National Telehealth Services, New Zealand
Patrick	Smith	National CEO	Canadian Mental Health Association
Mark	Snaterse	Executive Director, Addiction & Mental Health	Alberta Health Services
Katarina	Tabiova	Research Assistant	ACD Group, Department of Psychiatry, University of British Columbia
Anil	Thapliyal	CEO	HealthTRx, New Zealand
Krystle	van Hoof	Assistant Director	CIHR Institute of Gender & Health
Ashley	Walden	Director	Mental Health and Substance Use Branch, BC Ministry of Health
Nicholas	Watters	Director, Knowledge Exchange Centre	Mental Health Commission of Canada
Lori	Wozney	Research Associate	Centre for Research in Family Health

Appendix C: Seating plan

To facilitate the breakout sessions, participants were for the most part seated by jurisdiction. Jurisdictions were combined where there were too few representatives to fill a table.

BRITISH COLUMBIA (A)

Jane Burns, Founder and CEO, Young and Well Cooperative Research Centre
Francine Lemire, Executive Director and CEO, College of Family Physicians of Canada
Katie Hughes, Senior Director, Operations, Canadian Mental Health Association – BC Division
Kimberley Korf-Uzan, Manager, Provincial Programs, BC Mental Health & Substance Use Services
Lynn Pelletier, Vice President, Mental Health and Substance Use Services, BC Mental Health & Substance Use Services
Sandra Dawson, Advisory Council Member, Mental Health Commission of Canada
Ashley Walden, Director, Mental Health and Substance Use Branch, BC Ministry of Health

NEWFOUNDLAND AND LABRADOR

Leanne Boyd, Director, Policy, Research & Evaluation, Healthy Child Manitoba
Louise Bradley, President and CEO, Mental Health Commission of Canada
Fiona Choi, Postdoctoral Fellow, Department of Psychiatry, UBC
Lisa Crawley, Co-Chair, Canadian Alliance for Mental Illness and Mental Health
Niki Legge, Program and Policy Development Specialist, Government of Newfoundland and Labrador
Patrick Smith, National CEO, Canadian Mental Health Association
Anil Thapliyal, CEO, HealthTRx
Peter Cornish, Associate Professor and Director, Student Wellness and Counselling Centre, Memorial University of Newfoundland

BRITISH COLUMBIA (B)

Glenn Brimacombe, CEO, Canadian Psychiatric Association
Darrell Burnham, CEO, Coast Mental Health
Connie Coniglio, Provincial Executive Director, BC Mental Health & Substance Use Services
Amanee Elchehimi, Manager, Vancouver Education Services, Pacific Community Resources Society
Clare O'Donnell, Policy Analyst, Mental Health and Substance Use Branch, BC Ministry of Health
Mohammadali Nikoo, PhD Candidate, University of British Columbia
Hazel Meredith, Executive Director, BC Schizophrenia Society Victoria

ONTARIO, QUEBEC AND NEW BRUNSWICK

Fides Coloma, Manager, Mental Health & Addictions Branch, Ontario Ministry of Health & Long Term Care
Rita den Otter, Client Affairs Manager, BC Canadian Institute for Health Information
Nathalie Dumais, Présidente provinciale, Mouvement Santé mentale Québec
Eftyhia Helis, Knowledge Mobilization Officer, Canadian Agency for Drugs and Technologies in Health
Sylvie Martin, Director of Adult Services, Addiction and Mental Health Services, Government of New Brunswick
Krystle van Hoof, Assistant Director, CIHR Institute of Gender & Health

ALBERTA

Allison Bichel, Senior Provincial Director, Alberta Health Services
Karen Cohen, CEO, Canadian Psychological Association
Michael Krausz, Program Director, Addictions Psychiatry Department of Psychiatry, University of British Columbia
Catherine Pryce, Senator, University of Calgary
Mark Snaterse, Executive Director, Addiction & Mental Health Alberta Health Services
Amy Porath, Director, Research and Policy, Canadian Centre on Substance Abuse

NOVA SCOTIA AND PRINCE EDWARD ISLAND

Mark Ferdinand, Manager, Corporate Strategy and Development, Canadian Foundation for Health Improvement
Sam Hodder, Director, Mental Health, Northern Zone Mental Health & Addictions, Nova Scotia Health Authority
Fred Phelps, Executive Director, Canadian Association of Social Workers
Andrew Slater, Chief Executive, National Telehealth Services
Tracey Preeper, Senior Advisor to the Minister, Nova Scotia Department of Health and Wellness
Verna Ryan, CAO, Mental Health and Addictions, Acute Care, Health PEI

MANITOBA

Heather Hadjistavropoulos, Professor of Psychology, University of Regina
Teresa Jones-Dukes, Program and Policy Analyst, Healthy Child Manitoba
Shelagh Maloney, Vice President, Consumer Health, Communications and Evaluation Services, Canada Health Infoway
Anthony Phillips, Scientific Director, Canadian Institutes of Health Research, Institute of Neurosciences Mental Health and Addiction
Katarina Tabiova, Research Assistant, ACD Group, Department of Psychiatry, University of British Columbia
Elizabeth Lychuk, Manager, Child and Adolescent Mental Health Programs and Mental Health Promotion, Northern Regional Health Authority, Manitoba

NUNAVUT AND YUKON

Marie Fast, Clinical Manager, Mental Health Services, Department of Health and Social Services, Government of Yukon
Ian Hickie, Co-Director, Brain and Mind Centre, University of Sydney
Simran Lehal, Former Youth Council Member, Mental Health Commission of Canada
Victoria Madsen, Territorial Director of Mental Health and Addictions, Government of Nunavut
Lori Wozney, Research Associate, IWK Health Centre
Lisa Lachance, Executive Director, CYCC Network

Appendix D: Presenters Biographies

Hosts and speakers

Louise Bradley

A proud Newfoundlander, Bradley started her career as a registered nurse in Corner Brook, Newfoundland, where she discovered an immediate passion for mental health.

Bradley's work has taken her across the country, where she has held a range of positions across the health sector. From front-line nursing, to forensic and corrections care, to research, teaching, and large-scale hospital administration, Bradley has seen mental health issues on the ground and at the highest administrative level.

Bradley became President and CEO of the Mental Health Commission of Canada in 2010, after serving as Senior Operating Officer for the University of Alberta Hospital, one of Canada's leading clinical, research and teaching hospitals.

She holds degrees from Dalhousie University and Northeastern University in Boston, where she received a Master of Science with a specialization in mental health. She also received a Psychiatric Nursing Diploma with clinical practicum at Memorial University of Newfoundland's Harlow campus in Essex, England.

In June 2015, the Canadian College of Health Leaders presented her with the Innovation Award for Health Care Leadership for her work with the MHCC in encouraging future mental health pioneers. She was also given the Queen's Diamond Jubilee Medal in 2012 for her outstanding contributions to Canadian mental health.

In her years of work, Bradley has heard from hundreds of Canadians living with mental health problems and illnesses. Their stories are her inspiration to spark leading and lasting change for mental health care in Canada.

Nicholas Watters

Watters has significant experience working for not-for-profit organizations at both the national and provincial level with a focus on knowledge exchange, communications, capacity building, and network development and facilitation.

Watters has served on, and currently sits on multiple pan-Canadian networks aimed at increasing inter-organizational and inter-disciplinary collaboration, mobilizing best and promising practices, increasing the use of effective knowledge exchange principles and practices, while aiming to reduce silos and redundancy within the system.

Watters also has pioneered training and development courses across the health sector aimed at increasing capacity. Prior to joining the MHCC, he served as the Senior Advisor, Communications and Knowledge Transfer at the Chronic Disease Prevention Alliance of Canada.

Presenters

Dr. Lori Wozney

Wozney is a Research Associate at the Centre for Research in Family Health and human performance technologist. She completed her PhD in Educational Technology at Concordia University. Her research program seeks to improve health technology design to reduce inequalities in access to care for children and their families. Wozney has collaborated on and published numerous transdisciplinary reviews of eHealth interventions related to PTSD, pediatric anxiety and depression, mobile phone applications for depression and the implementation of e-Mental health in pediatric care.

Dr. Peter Cornish

Cornish's primary administrative responsibilities include managing and assisting in the development of programs for counselling, wellness education, chaplaincy at the Glenn Roy Blundon Centre for Students with Disabilities at Memorial University in St. John's, Nfld. A primary vision for these services is to promote academic, personal, career and spiritual development of students. Cornish is a strong advocate for inter-professional collaboration and encourages the development of partnerships with a broad range of disciplines (including medicine, nursing, psychology, social work, education and human kinetics) within the university and within the public health sector. His clinical and research interests include inter-professional team functioning, interpersonal and group dynamics, stepped-care programming, wellness community development, rural mental health service innovations and gender issues. His empowerment-oriented approach to professional practice draws heavily on feminist, brief interpersonal dynamic and solution-focused methods. Cornish is a registered psychologist (Newfoundland and Labrador, Saskatchewan) and works part-time in private practice with Cornish & Gilletta.

Dr. Heather Hadjistavropoulos

Hadjistavropoulos is a Professor of Psychology at the University of Regina. She completed her MA and PhD in Clinical Psychology at the University of British Columbia in 1995 and is a registered doctoral psychologist in Saskatchewan. She is a certified cognitive behaviour therapist with the Canadian Association of Cognitive and Behavioural Therapies, is listed with the Canadian Register of Health Service Providers in Psychology, and holds a Certificate of Professional Qualification in Psychology with the Association of State and Provincial Psychology Boards.

Hadjistavropoulos' clinical work is primarily with adults who have concerns with depression, anxiety and/or coping with medical conditions. She served as Director of Clinical Training in the Department of Psychology for 14 years and founded the Psychology Training Clinic at the University of Regina. She offers cognitive behavioural training for the assessment and treatment of anxiety and mood disorders to graduate students and professionals. Hadjistavropoulos has published and presented her research widely and received extensive national research funding.

In 2009, Hadjistavropoulos was funded by the Canadian Institute of Health Research and Saskatchewan Health Research Foundation to develop and evaluate the Online Therapy Unit for Service Education and Research (onlinetherapyuser.ca). She oversees the training and supervision of providers and students from diverse professional backgrounds on the delivery of online cognitive behaviour therapy.

Andrew Slater

Slater's background is in the health sector where he has held roles in transformation, strategy, human resources and change management. He first got involved with Homecare Medical to develop their telehealth and mHealth strategy and is now fully onboard as Homecare Medical's first CEO. In this strategic and operational leadership role, Slater is responsible for realizing the vision the Government have for the new national telehealth service. He played a key role in leading the 'transition' team to fully integrate services.

He is now focused on expanding the capacity and reach of health, wellness and mental health services to enable all New Zealanders to access quality care and support within their community in a way that is relevant to them personally. He is also responsible for ensuring Homecare Medical continues to be a trusted service, seamlessly connecting people with the right care and support. In its first year of operation the 300-person Homecare Medical team has provided support to one in ten New Zealanders.

Before joining Homecare Medical, Slater had a strategic leadership role in a health start-up which specializes in real-time health monitoring technology. Prior to this he was responsible for planning, service development and transformation for New Zealand's Ambulance Service. In this role he led the development of the first national plan for the ambulance service, including health sector engagement and integration.

In his roles, Slater's focus is always on doing the right thing for patients and the sector, a passion for better, being motivated by quality, and *pokohiwi ki pokohiwi* (standing shoulder-to-shoulder). In 2016 he was a finalist for New Zealand's Young Executive of the year and received the Auckland University of Technology eHealth Innovation Leadership Award. He has been described as a disruptive visionary, which is true, but makes him cringe.

Anil Thapliyal

Adjunct Professor Anil Thapliyal has a passion for improving people's health and wellbeing through the application of information communication technology seamlessly integrated within people's health care. He completed his postgraduate qualifications in Mental Health and Counselling field from the University of Auckland. Based on his longstanding work with the National Depression Initiative (The Lowdown and The Journal) in New Zealand, he decided to focus on the broader e-Mental health domain, and is professionally focused on the implementation of e-Mental health programs and services.

As a result, Thapliyal's work now is at the interface of the e-Mental health implementation science, which involves active consideration of (1) policy imperatives (public health, primary care, secondary care) (2) service user engagement in co-design (3) evidence-based approaches (science) (4) collaboration with the industry (5) aligning tools within the clinical workflow of practice environment and workforce development considerations.

Jane Burns

Associate Professor Jane Burns is the founder and CEO of the Young and Well Cooperative Research Centre, an organization that unites young people with researchers, practitioners and innovators to explore the role of technology in improving mental health and wellbeing for young people aged 12 to 25.

Burns holds a Principal Research Fellowship at Orygen Youth Health Research Centre and an Honorary Fellowship at the Brain & Mind Research Institute. She has led the youth agenda for *beyondblue*, was a Commonwealth Fund Harkness Fellow at the University of California, San Francisco, and was Director of International Partnerships at Inspire Foundation. Burns held a VicHealth fellowship from 2006-2013, an NHMRC fellowship from 1997-2000 and an NHMRC scholarship from 1994-1996. She holds a PhD in Medicine from the Faculty of Medicine (Public Health and Epidemiology), University of Adelaide.

Burns was a Victorian Finalist in the 2012 Telstra Business Women's Awards and was listed in the Financial Review and Westpac Group 100 Women of Influence in 2012. She is a Graduate of the Australian Institute of Company Directors.

Ian Hickie

Professor Ian Hickie is a psychiatrist and prominent mental health campaigner. He is a former NHMRC Australia Fellow heading the University of Sydney's Brain and Mind Centre as a Co-Director for Health and Policy, and is one of Australia's first National Mental Health Commissioners. The Commission oversees enhanced accountability for mental health reform in Australia. Hickie is an internationally renowned researcher in clinical psychiatry and a leading voice on mental health issues, with a special interest in youth mental health, and the prevention of and early intervention in emerging mood disorders. He has been instrumental in using clinical, health services and population health data to drive innovations in health services, particularly in primary care.

In partnership with Professor Patrick McGorry, he has been at the forefront of developing the youth mental health service headspace: the National Youth Mental Health Foundation. Hickie passionately advocates for enhanced health and social services for those with persistent mental illness and for increased accountability in the delivery of those services. As inaugural CEO of *beyondblue*: a national depression initiative, he established important depression awareness, prevention and early intervention programs. As Board Member for Research at the Mental Health Council of Australia (2003-2006), he was at the forefront of assessing consumers' and carers' experiences of mental health services. The findings underpinned the COAG agreement of 2006-2011 providing AUD5.5 billion in additional expenditure for mental health and the introduction of access to psychological services within the Medicare scheme.

Dr. Michael Krausz

Dr. Michael Krausz began his professional career in Germany, where he was trained at the University Medical Center Hamburg-Eppendorf as a registered nurse. He then went on to complete a residency in Adult Psychiatry and his Doctor of Philosophy, where he examined the associations between psychosis and addictions. In the mid-1990s, he became a founding director of the Centre of Interdisciplinary Addiction Research at the University of Hamburg. As founding director, he was responsible for the German Heroin Trial, the European Cocaine Project and several other notable addiction-related trials. He also served as Editor-in-Chief for two European scientific journals—*Suchttherapie* and *European Addiction Research*.

Krausz relocated permanently to Vancouver, Canada in 2007. From 2009–2012, he was the Medical Director of the Burnaby Centre for Mental Health and Addiction with Vancouver Coastal Health. Currently, he is a Professor of Psychiatry at the University of British Columbia (UBC) and is the Providence Health Care B.C. Leadership (LEEF) Chair in Addiction Research at the UBC Institute of Mental Health. As head of the

Addictions and Concurrent Disorders Group at CHEOS, Krausz's research explores the relationship between early life trauma, substance use disorders, and other mental illnesses. His research includes the *At Home/ Chez Soi* study, the B.C. Health of the Homeless Survey and the Study to Assess Long-Term Opioid Maintenance Effectiveness (SALOME). He has published more than 300 scientific papers to date.

More recently, Krausz has extended his expertise to include e-Mental health. The Bell Youth Mental Health IMPACT Project (2012) was his first endeavour in this area. Bell Canada's philanthropic support in the amount of \$1 million as part of their Let's Talk Initiative was critical seed funding in the development of a new mental health platform, WalkAlong, designed to provide youth who are experiencing depression and anxiety with resources to help foster mental wellness. In 2014, he was recognized for his tireless research and advocacy related to substance use, mental health and housing security with the City of Vancouver's Healthy City for All Award of Excellence.



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