COVID-19 SHEDS LIGHT ON NEW POSSIBILITIES IN ONLINE THERAPY AND COUNSELLING

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Executive Summary

The arrival of COVID-19 in Canada resulted in government-mandated physical distancing including restrictions on in-person medical treatment. The specific directives varied province by province and changed over time. In Ontario, while hospitals remained open, hospital activity was limited to urgent or acute care and all other essential care was provided through electronic channels where possible. The mental health and addiction sector responded quickly, moving most community and hospital-based therapy, counselling and other supports to audio or video-based services for individuals who were interested and able to do so, while maintaining in-person support where deemed essential such as housing and injection sites. The purpose of this project is to investigate the effectiveness of online therapy and counselling during this period of mandated physical distancing to inform how online therapy and counselling may be effectively implemented post COVID-19.

The recommendations in this report are informed by research that included 17 telephone interviews with Ontario-based therapists, counsellors, and leaders of mental health and addiction organizations and one focus group of organization leaders who provided feedback and further insights based on a review of the findings from the telephone interviews. An extensive review of literature from scholars, governments and non-governmental organizations also helped to provide context and relevant learning from studies that took place prior to COVID-19.

For context, major findings from the literature review included:

- Globally, the total estimated economic output lost to mental, neurological and substance use disorders in 2010 was $8.5 trillion and the burden of mental, neurological and substance use disorders increased by 41% between 1990 and 2010 (Patel et al., 2016).
- One in five Canadians reported living with a mental health problem and the system is significantly underfunded relative to other OECD countries (Mental Health Commission of Canada, 2017).
- 38% of Canadians with a mental health issue or substance use disorder reported that symptoms started before age 15 (Canadian Institute of Health Information, 2019).
- Less than 10% of patients with severe mental health problems have access to a therapist in person (Ashcroft, Insua-Summerhays & Schurter, 2016).
- The mental health and addiction system in Ontario is complex and disconnected (Bullock & Lavis, 2019; Government of Ontario, 2020)
- Online interventions widen access to people who might not otherwise receive mental health support (Ashcroft, Insua-Summerhays, and Schurter, 2016)
- Online psychological services can be as good as services provided face to face, but it is difficult for users to distinguish between various services and determine which ones may be most appropriate for them (Dowling and Rickwood, 2013).
- Early research on internet-based cognitive behavioural therapy has been positive, it may only be appropriate for some patients and some circumstances (Gratzer, 2020).
- A meta-analysis of eleven studies on the effectiveness of telephone-based therapy determined that it can be very effective, but more research was required to establish applicability and cost-effectiveness (Haregu, Chimeddamba & Islam, 2015)

The research findings were mostly consistent with the literature, concluding that online therapy and counselling can be very effective. The research also filled some of the gaps or inconsistencies in the literature regarding who would benefit and in what circumstances. Five major themes emerged from the research including:

- Convenience and flexibility were mentioned by 16 of 17 research participants (94%). This included convenience for both the therapists/counsellors and the clients. For therapists, working from home meant better work/home balance as it eliminated the travel time to and from work and for some, it also eliminated travel time to see clients at their homes. For clients, it meant not having to take as much time off work to attend therapy, not having to navigate bad weather or poor transportation options. For both, it provided more flexibility in scheduling appointments, providing more options and fewer restrictions.
- Access was mentioned by 16 of 17 interviewees (94%) but perceptions were mixed. A total of eight interviewees (47%) perceived access to be better since people living in remote areas, housebound by physical or mental illness, without transportation, or unable to get necessary time off work or away from family were able to access online support. Conversely, four of 17 interview participants (24%) perceived access to be reduced
- Impact, described as the ability for the therapy delivered online to have a positive impact, was mentioned by 15 of 17 participants (88%). Of the 15 participants who mentioned impact, 12 described mixed results.
- Efficiency and cost savings related to online therapy and counselling were mentioned by 12 participants (71%). These respondents perceived a positive relationship between efficiency/cost savings and online treatment.
- Equity was raised by a total of 11 participants (65%) with nine of the 11 who mentioned equity (82%) citing online as negatively associated with equity and two participants

providing a mixed view. No participants positively associated online therapy and counselling with equity

This report includes seven recommendations directed toward the Government of Ontario and the mental health and addiction community. It is hoped that government and the mental health and addiction community will act on this research while there is still time to inform policies and protocols post COVID-19. The research findings provide the groundwork to develop a set of guidelines that will be critical in guiding the transition back to a blended model of delivery and it is recommended that the development of these guidelines be led by the community, where the deep knowledge and experience from the last nine months resides.

It was difficult to look at online modalities in isolation given the many challenges that the mental health and addiction system faces and for that reason, the recommendations in this report go beyond the evaluation of online delivery. Government and non-government stakeholders must work together to rebuild and repair a mental health care system that all agree is underfunded, disconnected, and highly stigmatized. It is also imperative that the voices of those with lived experience are included in this discussion as we cannot even begin to place ourselves in their position from our place of power, privilege and well-being.

Online therapy and counselling provide significant opportunity to improve access, increase efficiencies, and reduce barriers but its integration must be carefully and cautiously planned to ensure that care is improved for all and not improved for some and reduced for others. It is my hope that the learning and recommendations in this report help to pave a way forward that is grounded in evidence, supported by the community, and can make a positive difference in the lives of the millions who suffer with mental health and addiction in Ontario, the rest of Canada, and around the world.

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Focus and Framing

As a result of the global COVID-19 pandemic, mental health and addiction services around the world have had to change or modify service delivery to reduce risk of transmission among both patients and providers. In Canada, the majority of therapy and counselling for people living with mental and substance use disorders transitioned from in-person to online. In Ontario, where this research took place, hospitals services were limited to urgent or acute care and all other in- person care was transitioned to online where possible. Mental health and addiction organizations responded quickly, moving therapy and counselling to telephone or videoconferencing for patients who were interested and able to do so, while maintaining in-person support where deemed essential such as housing and injection sites. The purpose of this project is to investigate the effectiveness of online therapy and counselling during this period of limited face to face contact to inform how the healthcare system can integrate online therapy and counselling post COVID-19 most effectively.

This report was informed by an in-depth review of more than 40 books, articles and reports written by scholars, practitioners, government organizations and non-governmental organizations. Recommendations were based on research which included 17 telephone interviews with therapists, counsellors, and organization leaders who experienced online therapy and counseling firsthand during the pandemic and one focus group of organization leaders (a subset of those who participated in interviews) who provided feedback on the findings from the interviews and additional insights on issues and opportunities regarding online therapy and counselling. While I was unable to include the voices of those with lived experience directly, I hope that there will be opportunity in the future for these perspectives to be included prior to the implementation of recommendations.

The World Health Organization (n.d.) defines mental illness as a behavioural syndrome that interferes with an individual's thought processing abilities, social abilities, emotions and behaviours.

Globally, common mental health disorders, including depression, anxiety, and post-traumatic stress disorders, are estimated to impact 17.6% of the population (Singla, D, et al., 2017). According to Patel et al. (2016), the global burden of mental, neurological and substance use disorders increased by 41% between 1990 and 2010. It is estimated that one in five Canadians are affected by mental illness (Smetanin et al., 2011, Canadian Institute for Health information, 2019). The burden of mental illness is more than one and a half time that of all cancers and more than seven times all infectious diseases as measured by health-adjusted life years (HALYs) (Ratnasingham et al., 2012). Yet, according to several studies and reports (Ratnasingham et al., 2012; Mental Health Commission of Canada, 2017, Alhawshani et al., 2019), needs are not being met.

The literature suggests that the current mental health system in Canada is not meeting the needs of the community it is intended to serve. One reason is that the mental healthcare system in Canada is considered by many to be underfunded. The Mental Health Commission of Canada (2017) reported that, in 2015, Canada spent 7.2% of health dollars on mental health versus France at 15%, England at 13%, and Germany at 11%; and versus a mental health disease burden estimated at 23% of total disease burden in Canada. It is also estimated that 59.6% of spending on mental health went to hospitalization, noting that hospital services, including emergency department, inpatient or psychiatric services, are most often aimed at stabilizing the condition vs. making people well (Canadian Institute of Health Information, 2019). The Mental Health Commission of Canada (2017) also reported that 85 children's mental health centres had wait times as long as 18 months, and more than 11,000 people were on wait lists for supportive housing in Toronto alone. There is the potential for online modalities to reduce wait times, increase early intervention, and reduce the cost per person served, and thereby at least partially address this funding gap, but as explored in this report, effective implementation will be key.

In addition to being underfunded, the system is highly complex. According to the Government of Ontario (2020), the system is disconnected and fragmented, making it challenging for individuals to access services. A report delivered by The Standing Senate Committee on Social Affairs, Science and Technology (2004) stated that the mental health and addiction system in Canada is not, in fact, a real system, but a complex array of services delivered by a number of providers, often operating in silos. Ofek (2016) argued that the more complex the program or system, the more difficulty in evaluating it effectively. This argument was also supported by Bullock and Lavis (2019) who stated that because the mental health system in Canada is both complex and fragmented, it is difficult to achieve system change. The complexity of the current system also makes it more difficult to determine when, where, and how to best integrate online therapy and counselling. For example, should it be integrated by every clinic or practitioner or should it be implemented as a centralized service?

In addition to underfunding and system complexity, there are also societal factors that influence access to services. Socioeconomic adversities increase risk of mental health and substance use disorders and, at the same time, people with mental health issues are more likely to drift Into poverty due to stigma, discrimination and reduced ability to maintain employment (Patel et al., 2016). This argument is further supported by Knaak, Livingston, Stuart, & Ungar (2020) who argued that stigma or discrimination attached to mental illnesses presents a serious barrier to both treatment and acceptance. The Senate Report prepared by The Standing Senate Committee on Social Affairs, Science and Technology (2004), included a quote from Dr. John Arnett, Head, Department of Clinical Health Psychology at the University of Manitoba:

> *We know that stigmatization is characterized by bias, distrust, stereotyping and so on. It frequently reduces an individual's access to resources and opportunities for housing and jobs and ultimately leads to low self-esteem, isolation and hopelessness. There is no question that this*

> *occurs in many cases independently of the limitations that may be imposed by the mental health disorders themselves. In other words, stigmatization seems to have an independent capacity to do this.* (p. 43)

There is clearly potential for online therapy and counselling to at least partially respond to the needs of marginalized groups where barriers like access and discrimination are more prevalent, but attention must be focused on what is therapeutically appropriate versus convenient or lower cost.

Days prior to the government mandated closure of most in-person mental health and addiction services, the Government of Ontario announced a $3.8 billion investment in mental health. The announcement included the establishment of the Mental Health and Addiction Centre of Excellence, responsible for system management and standardizing and monitoring the quality and delivery of services. (Government of Ontario, 2020). The Centre will be responsible for implementing the plan which is comprised of four pillars:

- Pillar 1: improving quality includes the development of a core services framework based on severity and complexity of needs, the development of a data framework and real time access to digital health records;
- Pillar 2: expanding services including early identification and intervention for children and youth, supportive housing for low income people with mental health and addiction challenges, and improved services for Indigenous communities;
- Pillar 3: implementing innovative solutions including a program called Mindability that provides cognitive behavioural therapy (CBT) for the treatment of depression and anxiety in a range of formats including telephone coaching, internet-based CBT group and individual counselling and in-person group and individual therapy. This pillar also includes the expansion of addiction services and the implementation of policies and programs to address opioid

addiction. It also includes the expansion of youth wellness hubs with walk-in access to a range of services including mental health and addiction services.

- Pillar 4: improving access to ensure that people know how and where to get the help they need, including text and phone navigation services and regional in-person support at sites across the province. This pillar also includes the expansion of the recently introduced Ontario Health Teams that will integrate care delivery to enable providers and recipients of care to work together more effectively, including the active involvement of primary care providers throughout their patients' health journey.

It is not surprising that the Government of Ontario plan included telephone-based therapy (TBT) and internet-based cognitive behavioural therapy (iCBT) as these modalities have been available for many years and significant research has shown that both modalities are effective in some cases (Dowling & Rickwood, 2013; Kunkle et al., 2020; Brenes et al., 2011; Simon et al., 2004; Dobkin et al., 2020; Gratzer, 2020; Ashcroft et al., 2016; Cangelosi and Sorrell, 2014). The Government announcement was, however, pre-COVID-19, when adoption of online modalities was still limited and most studies argued that more research was required to establish applicability, effectiveness, and real costs (Dowling & Rickwood, 2013; Kunkle et al., 2020; Simon et al., 2004; Dobkin et al., 2020). A study conducted by IJzerman, van der Vaart, and Evers (2019) investigated why adoption of online modalities remained low (16% in this Dutch study) despite high availability and significant evidence supporting its use. The study (IJzerman et. al., 2019) concluded that "the needs and beliefs might not be strong enough to create actual behavioural change" (p. 6). COVID-19 has now created that urgent need, resulting in unprecedented adoption in a short period of time, and the opportunity to further evaluate benefits, limitations and opportunities for integration.

It is the aim of this research to learn more about how online therapy and counselling might best be integrated into the system in Ontario to expand access and maximize impact. It is hoped that this

research is also leveraged by governments and communities in other provinces across Canada and other countries around the world that are facing similar challenges. The research conducted during this COVID-19 period is aimed to address the gaps in the literature; specifically, the question of when and for whom online therapy and counselling may be therapeutically appropriate. The research also provides an opportunity for experts living and working in communities across Ontario to be heard, and for their expertise and experiences of delivering therapy both online and in-person to be added to the existing literature. It is also hoped that this report may assist in facilitating discussions between stakeholders and policy makers before planned Government initiatives are finalized and post-COVID-19 guidelines are determined.

Literature Review

The purpose of this project is to investigate the effectiveness of virtual therapy and counselling during the period of COVID-19 physical distancing restrictions and to determine what aspects of virtual therapy should become part of the 'new normal' treatment protocol post COVID-19 in Ontario, Canada and potentially beyond. This literature review aims to provide relevant learning and a range of perspectives from across the globe, to inform the focus of my research and my recommendations. The literature has been organized into three distinct themes: Mental Health and Addiction Prevalence, Costs and Funding; Evaluating the Mental Healthcare System; and Effectiveness of Therapy and Counselling.

Mental Health and Addiction Prevalence, Costs and Funding

This section aims to provide a general overview of mental health and addiction. It also provides information of who is affected, trends in prevalence, and the impact that these illnesses have on individuals directly affected, society as a whole and the Canadian economy.

Mental illness is defined as a behavioural syndrome that interferes with an individual's thought processing abilities, social abilities, emotions and behaviours (World Health Organization, n.d.). Globally, common mental health disorders, including depression, anxiety, and post-traumatic stress disorders, are estimated to impact 17.6% of the population (Singla, D, et al., 2017). Patel et al. (2016) also claimed that, globally, the burden of mental, neurological and substance use disorders increased by 41% between 1990 and 2010.

In Canada, it is estimated that one in five Canadians are affected by mental illness (Smetanin, P., Stiff, D., Briante, C., Adair, C.E., Ahmad, S. & Khan, M. 2011). The report by Smetanin et al. (2011) estimated the health and economic impact of mental illness and projected impacts over 2011 to 2041. The report estimated that over 6.7 million Canadians were living with a mental illness in 2011. It is

forecasted that this will grow to over 8.9 million by 2041, representing 20.5% of the population. The report also estimated that almost 1.2 million children and adolescents (9-19) will be living with a mental illness by 2041. The increases are claimed to be driven by population growth and aging. A Statistics Canada Canadian Mental Health Survey conducted in 2012 and referenced by Wang et al. (2017) suggested that incidence of a mental or substance use disorder was one in 10 or 2.8 million in 2011, a significantly lower number than reported by Smetanin (2011). Sutherland and Findlay (2013) also utilized the Canadian Mental Health Survey (CMHS) in their analysis and concluded that 17% of respondents reported having had a need for mental health services in the previous 12 months. Sutherland and Findlay (2013) also reported that regardless of the mental health or substance disorder, the most commonly reported need was for counselling. Counselling was also the least likely need to be met with only 65% of study participants reporting that their need for counselling had been met. The study also reported individuals with a higher level of distress were more than three times as likely to have unmet needs and more than seven times as likely to have partially met vs. met needs. The study also showed that people with two or more chronic physical conditions were less likely to have an unmet mental health care need. While not explained in the report, this may be a result of being more closely monitored by a physician. It is also important to note that one of the reasons that the reported incidence of mental health or substance disorder in the Canadian Mental Health Survey is lower than in the Smetanin (2011) study is related to methodology. In the CMHS, mental disorders were identified by responses from participants and not a clinical diagnosis and not all mental disorders were included. It was also noted that the sample did not include the institutionalized population. The study also acknowledged that it would be valuable to include factors such as having a family doctor or insurance coverage which may influence likelihood to access the system and have needs met.

Globally, the total estimated economic output lost to mental, neurological and substance use disorders in 2010 was $8.5 trillion (Patel et al., 2016). It was also estimated that this sum would double

by 2030 unless significant investments are made. Smetanin (2011) estimated that the cost to the Canadian economy in 2011 was $42.3 billion and projected the cost to grow to $291 billion by 2041. The 199-page comprehensive report by Smetanin (2011) is commonly referenced in Canadian government and non-governmental reports and scholarly articles and appears to form the basis of many studies about mental health and addiction in Canada. The report used a simulation platform to generate the model for both current and future life and economic outcomes and included inputs from many databases and evidence-based sources. In terms of limitations, the model did not take all risk factors into account in its predictions such as changes in the population's socioeconomic status. An independent panel of experts, including recognized epidemiologists, researchers, and clinicians, was consulted throughout the project to assist with data gathering and validating approaches and assumptions. A report conducted by the Mental Health Commission of Canada (2017) estimated the total cost of mental illness to the Canadian economy in 2016 to be well over $50 billion, generally consistent with Smetanin's estimate of $42.3 billion in 2011. This second estimate was based on data from four studies conducted between 2008 and 2016, including Smetanin's study.

In addition to the size and cost of mental illness and addiction in Canada, several studies have looked at the impact on quality of life and mortality vs. other illnesses. A 2012 study by Ratnasingham, Cairney, Rehm, Manson, and Kurdyak aimed to quantify the burden of mental health and addiction in Ontario and compared mental illness and addiction with other diseases and conditions. The report defined burden based on years of life lost due to premature mortality as well as year-equivalents of reduced functioning. It calculated health-adjusted life years (HALYs) by combining years of life lost and year-equivalent of reduced functioning. While, in this study, mental health and addiction accounted for significantly fewer years of life lost compared with cancer and infectious disease, it showed a dramatically higher level of years of reduced functioning resulting in a much higher HALY. The report identified depression, bipolar disorder, alcohol use disorders, social phobia and schizophrenia as the major

contributors with depression accounting for the highest level of overall burden and alcohol use accounting for 88% of deaths. The study estimated the burden to be more than 600,000 HALYs. The report concluded that mental health and addiction is under-recognized and under treated. It also claimed that while effective treatment exists for mental health and addiction, only a small proportion of affected individuals receive treatment, demonstrating the need for increased health promotion, prevention intervention and access to treatment. The report also claimed that the high burden is partially due to the emergence of conditions early in life and exacerbated when no treatment is received, once again reinforcing the need for prevention among children and youth and early intervention. The report by the Canadian Institute of Health Information (2019) reinforced this point, stating that 38% of Canadians with a mental health issue or substance abuse disorder reported that symptoms started before age 15. Patel et al. (2016) concurred, stating a high propensity for mental health and substance use disorders to appear early in life, contributing to large contribution to the global disease burden.

Another area of relevance to this project is the issue of funding. The report by the Mental Health Commission of Canada (2017) used OECD (2014) data to demonstrate the underfunding of mental health in Canada. The report claimed that mental health is underfunded in most countries. Patel et al. (2016) estimated that less than 1% of development funding aimed at improving health in low-income and middle-income countries is allocated to mental, neurological and substance use disorders. The Mental Health Commission of Canada (2017) reported that mental health disorders were significantly underfunded in Canada as compared with other developed countries. It also claimed that while mental illnesses represent 23% of total disease burden globally, it received far less in health spending. The report showed that in 2015, Canada spent 7.2% of health dollars on mental health vs. England at 13%. It is also important to note that Wang et al. (2017) reported that 59.6% of the spending on mental health in Canada was in hospitalization and that between 2003 and 2013, inpatient costs increased substantially in most provinces.

The report (Mental Health Commission of Canada, 2017) also included several studies that have demonstrated the relationship between social determinants like food insecurity, poverty, and poor access to healthcare and likelihood of developing a mental health problem. Patel et al. (2016) also suggests a cyclical pattern exists where socioeconomic adversities increase risk and people living with mental health issues are more likely to drift into poverty due to stigma, discrimination and reduced ability to maintain employment. According to Patel (2016), "Understanding the vicious cycle of social determinants and MNS (mental, neurological, and substance use) disorders provides opportunities for interventions that target both social causation and social drift" (p. 1673).

Evaluating the Mental Healthcare System

This section reviews literature that examines the mental healthcare system. It aims to identify the system strengths and gaps in Canada and compares the system in Canada to systems in other countries. This section starts with a discussion about evaluation methods and challenges.

According to Guba and Lincoln (as cited in Russ-Eft and Preskill, 2009), "evaluation is always disruptive of the prevailing political balance" (1981, p. 299) and by its very nature, evaluation surfaces conflicts among stakeholders. According to Patton (2018), evaluation is difficult because it leads to changes that typically result in a loss of power or assets. In addition, the person or entity commissioning and/or conducting the evaluation may be conducting the evaluation with a preferred outcome in mind (Russ-Eft & Preskill, 2009). As a result of these factors, the scope, participants, evaluator design, timing, etc. can significantly influence the outcome (Russ-Eft & Preskill, 2009).

Systems also present challenges as they are comprised of interdependent parts where a change in one part can affect other parts and each part is a sub-system within the larger system (Laszlo, 1996). The mental healthcare system is comprised of many sub-systems including, for example, the hospital system, the family physician, the clinic providing psychotherapy or counselling, the government providing

funding, and the support system of the patient. Each sub-system has an impact on the outcome and changes to one could impact changes in others. Ofek (2016) also argued that the more complex the system being evaluated, the more difficult it is to evaluate it effectively. Bullock and Lavis (2019) described the mental health system in Canada as being both complex and fragmented, making it challenging to evaluate and to achieve systemic change.

Many scholars, including Wolfe, Long, and Brown (2020) and Patton (2018) have supported the need for principles-focused evaluation, particularly when there are significant societal implications. In principles-focused evaluation, principles are established to guide decisions and set priorities. An example of where this may be relevant in the evaluation of mental health systems would be the issue of equity. Is it a principle that all citizens would have equal access to all resources or should the evaluation prioritize certain communities over others? When evaluating online therapy, is it being compared to in-person therapy or, in the case of someone living in a remote community, compared to no therapy? Principles-based evaluation also includes addressing root versus surface-level causes (Patton, 2018), a critical consideration in evaluating mental health and addiction systems. An example could be evaluating the reasons why incidence of mental health and addiction disorders is increasing among teens and determining how to prevent issues versus solely focusing on expanding services to treat growing numbers.

There is little debate in the literature that the mental healthcare system in Canada is not working effectively. Gratzer (2020) argued that there is a mental health care gap in Canada and that only a minority of Canadians with mood and anxiety disorders have access to treatment. The Government of Ontario (2020) stated that mental health and addiction services are disconnected and fragmented. This was further supported by the Standing Senate Committee on Social Affairs, Science and Technology Report (2004) which stated that the mental health and addiction system is not, in fact, a real system but a

complex array of services delivered by numerous providers, often operating in silos. The Senate Committee Report (2004) also indicated that the problem dated back to deinstitutionalization in mid-1950's where psychiatric hospitals were closed and it was expected that community services and general hospitals take on the responsibility of serving the mental health community. The Senate Committee Report (2004) stated that the new system of care was not adequately funded and a roadmap indicating how the new system was expected to operate did not exist. Bullock and Lavis (2019) described the mental health system as "a suite of fragmented services delivered with varying levels of intensity and effect across services and sectors" (p. 2). According to a study by Fikretoglu and Liu (2014) that analysed data from the Canadian Community Health Survey, 16.9% of new onset cases reported perceived unmet needs. Among these individuals, acceptability was reported by 77% as a barrier, about ten times as often as accessibility and four times as often as availability. To further clarify this finding, the specific reasons given included a preference to manage oneself; a belief that nothing could help; a lack of knowledge about how or where to get help; a fear of asking for help; embarrassment or of what others would think; language barriers and family responsibilities. These barriers decrease in frequency relative to education level and societal conditions, emphasizing that barriers are more prevalent among those with the least power and resources (Fikretoglu & Liu, 2014). This finding indicates that online therapy and counselling could not only address accessibility but also address the barrier of acceptability by providing greater privacy and less disruption to work and family responsibilities.

A study published by CIHI (2019) also stated that because mental health and addiction services are provided across many settings, there is a need for better integration to ensure continuity of care across community, emergency department and hospital care. Another report published by Children's Mental Health Ontario (2020) indicated an unacceptable wait time rate (28,000 children and youth waited as long as 2.5 years in 2019). CMHO (2020) also claimed that wait times create a burden on other parts of the system including schools and hospitals, noting that according to the CIHI analysis,

hospitalization of children and youth with mental health and addiction issues has increased by 90% over the last 11 years and emergency department visits have increased by 83%. The CMHO report also indicated that there were major gaps in services or no services at all in many rural and remote communities. It is estimated that 200,000 children and youth who needed help did not even make it to wait lists (CMHO, 2020; Ontario Child Health Study, 2014). This points to an opportunity to integrate online therapy and counselling as an early intervention to lessen wait lists and provide access to some services in remote communities. And while the Government of Ontario plan includes integration of care delivery using recently introduced Ontario Health Teams, this strategy will only be effective if there are specialized resources available including psychologists, psychotherapists and counsellors.

As a result of limited specialized resources, family physicians delivered almost two-thirds of mental health services in Canada, despite their limited training (Alhawshani et al., 2019). Alhawshani (2019) also argued that while psychotherapy is typically preferred by patients, many cannot access it because of limited availability of publicly funded services. This finding was supported by a Canadian Institute of Health Information report (2019) which stated that 30% of primary care physicians reported seeing patients with substance use issues and 51% reported seeing patients with severe mental health problems but only 15% and 23% respectively felt prepared to care for those patients. According to CIHI, 84% of family physicians provided psychiatric care or counselling in the 2016-1017 reporting year.

There are both similarities and differences in comparing the system in Canada to other countries. According to Patel et al. (2016), most low-income and middle-income countries have not made mental health and addiction a priority due to competing priorities, a lack of political will, and a heavy dependence on hospital-based care. However, in China, significant investments in the public health system were made following the 2003 SARS outbreak (Ma, H., 2012). This included investments in and integration of hospital and community-based mental health services. It also included significant training of mental health

professionals and a seven-fold investment in non-mental health professionals (Ma, H., 2012). One metric reported from this major system change was that the relapse rate (defined as no relapse of acute systems for 5 years or longer) among patients with severe mental illness went from 67% in 2005 to 90.7% in 2011 (Ma, H., 2012). Singla et al. (2017) also evaluated the effectiveness of non-specialist providers (NSP's) in providing treatment for common mental disorders such as depression and anxiety in low-income and middle-income countries. Based on 27 trials in low- and middle-income countries, Singla et al. (2017) determined NSP's to be highly effective in reducing the mental health burden. Raviola et al. (2019) claimed that research conducted in India, South Africa, Ethiopia, Nepal, and elsewhere have demonstrated the effectiveness of NSP's for a range of mental health conditions. Raviola (2019) also argued that while there has been minimal adoption or evaluation of this model in higher-income countries, there is no apparent reason why it would not have similar impact if integrated properly. In looking at the system more broadly, Raviola (2019) advocated for a collaborative systems-based task-sharing framework which included self-care, peer to peer support, NSP's, community-based nurses, social workers, psychologists, family physicians and psychiatrists working together across a range of locations from home to community to clinic to hospital. Patel et al. (2016) supported a model of "collaborative stepped care" (p. 1679), where a non-specialist case manager performs screening and monitoring and coordinates care among the service providers. This model would lend itself to the integration on online therapy or counselling where an online intervention is attempted first and if deemed unsuccessful, a step up to a higher level of care is administered. Conversely, many European countries such as Finland (Gutierrez-Colosia et al., 2019) remain highly dependent on inefficient hospital-based systems and despite improvements in community care in countries like Sweden, where the principle of achieving "good health on equal grounds for the entire population" is an established priority (Bramesfeld et al., 2016), those with privilege and power are still accessing treatment more often than those without (Olsson et al., 2020).

Another issue regarding the evaluation and improvement of mental health and addiction systems issue is the lack of available data (Canadian Institute of Health Information, 2018). A working group headed by Canadian Institute of Health Information (CIHI), that included representation from federal, provincial and territorial governments, reported that existing measurement and reporting across the country was mainly associated with hospital care. The working group found that little to no measurement was available on community care including access, wait times and client outcomes (CIHI, 2018). In order to identify gaps and inconsistencies in measurement, the working group mapped existing measures to CIHI's Health System Performance (HSP) Measurement Framework. The HSP framework centred grouped measurements into four areas: person-centred, safe, appropriate and effective, and efficiently delivered. Further complicating measurement and system integration is that, unlike most other areas of healthcare in Canada, a significant portion of services is delivered by private, for-profit providers, where service delivery decisions are made by operating boards vs. government (Bullock & Lavis, 2019). Another factor adding to the complexity of measurement is that even publicly funded community mental health care is delivered in a variety of settings including doctor's offices, community centres, homes, schools, supportive housing units, and telehealth services (CIHI, 2018).

In summary, while mental health and addiction systems vary widely around the world, underfunding and lack of integration of treatment and services are prominent issues in most countries. The utilization of online modalities, up until COVID, was minimal (IJzerman, R., van der Vaart R., & Evers A., 2019) as the need, until now, was not strong enough to create behaviour change. Most scholars and practitioners would agree that there is a need for change given the heavy burden of mental health and the significant gap in services, yet evaluating the current system is both highly complex and highly political, balancing rights with costs (Patel et al., 2016). Knaak, Livingston, Stuart, and Ungar (2020) also argued that there is structural stigma in the mental health care system that must be addressed. In this

report, structural stigma was defined as the activities of systems and organizations that create and maintain social inequities, both deliberately and inadvertently.

There is also a large body of evidence supporting the integration of non-specialist practitioners (Ma, 2012; Singla, 2017; Raviola, 2019) in low-, medium-, and high-income countries but progress is slow in most countries. One issue slowing adoption is concern by mental health professionals that they would lose power or identity (Raviola et al., 2019), once again raising the issues of politics (Russ-Eft & Preskill, 2009) and power (Patton, 2018) in systems change. Given the complexity of the system combined with known challenges and gaps, Ofek's (2016) suggestion to start with a theory of change method, where causality is demonstrated through a constructed model, before proceeding with impact evaluation may hold significant merit in the case of the mental healthcare system. This would allow for each issue to be addressed with a targeted approach and allow for the impact of each specific change to be measured. Also, given the broad adoption of online therapy and counselling during COVID-19, this is an ideal time to evaluate models for the integration, with a wide range of implementations and learnings to evaluate currently in place.

Effectiveness of Therapy and Counselling

This section reviews literature on the effectiveness of mental health and addiction therapy and counselling. It also includes specific research about online therapy with a focus on telephone and video conference modalities. One of the key themes that emerges in this section and is reinforced in my research is the variability of effectiveness of both in-person and online therapy and counselling depending on a wide range of factors, including factors that are difficult to measure, such as therapeutic relationship.

According to WHO (n.d.), most mental illness disorders can be successfully treated. Patel et al. (2016) described three treatment delivery platforms: self-management, primary health care (including

psychological and pharmacological methods) and hospital care. Singla et al. (2017) stated that empirically supported psychological treatments are among the most effective interventions for treatment of common mental disorders. Patel et al. (2016) claimed that a wide range of interventions could be used depending on the patient's specific needs; including drugs, psychological, medical and social interventions. Patel et al. (2016) also claimed that while interventions can reduce the severity of most illnesses, few curative interventions exist. There is also significant evidence supporting the use of cognitive behavioural therapy (CBT) where patients identify dysfunctional thinking and behaviours and replace them with more adaptive ones (Chawathey & Ford, 2016). Chawathey and Ford (2016) referenced many studies including controlled trials that showed favourable results, and the endorsement from National Institute for Health and Care Excellence in the United Kingdom which recommended CBT as a primary therapy for a range of psychological disorders including anxiety, depression and obsessive-compulsive disorder.

Norcross and Wampold (2011) argued, however, that in order for therapy to be effective, it needs to be adapted to the individual patient. This paper, based its findings on research conducted by the American Association's Division of Clinical Psychology and Psychotherapy, indicated that four characteristics from a list of 200 were determined to be most important in adapting psychotherapy to the patient. These characteristics were reactance/resistance, preferences, culture and religion/spirituality. The paper argued that different patients require different treatments and different relationships.

Miller (2020) shared that evaluation of psychotherapy is based on a medical model and questioned if this model of evaluation is appropriate. He raised concern that the model is based on following very specific and prescriptive steps for diagnosis and treatment and if those steps do not work, the patient is to blame (resistance, attachment, etc.). Miller (2020) suggested that a contextual model would be more effective as it involves consideration of factors such as culture, location, and the person(s)

involved. A contextual model also considers whether a particular therapist is a fit for the patient, depending on contextual considerations. Miller (2020) also argued that the alliance is the construct that separates highly effective vs. average therapists. He also emphasized that therapists who are responsive to the individual client have better outcomes which means that improvisation is required to maximize effectiveness and responsiveness is therefore is a critical measure of effectiveness.

Eugster and Wampold (1996) found significant differences in how patients and therapists evaluate psychotherapy sessions. Both patients and therapists saw patient involvement and patient progress as significant and positive predictors of session evaluation. A significant difference between therapist and patients was that therapists placed a high value on therapist expertness while, according to patients, session evaluation was best predicted by the therapist 'real relationship' (Eugster & Wampold (1996). These results suggested that when a patient perceives that they are being related to in a manner not solely prescribed, he or she is likely to evaluate the session more positively. This would include subtle cues like authenticity and the sense that the therapist is willing to be perceived and related to as a person within the context of a genuine human relationship. According to Eugster and Wampold (1996), this is consistent with other studies that have shown that the 'person' of the therapist is most instrumental to change. The authors also suggested that the therapists' leaning toward expertness as a more significant factor may be a result of years of schooling and training where they are rewarded for technical proficiency. The authors also argued that it was important for therapists to recognize the value of human involvement on the part of the therapist and view camaraderie between therapist and patient as part of the therapeutic process. This also raises important concern about the role of the patient in evaluating the effectiveness of therapy and to what extent their self-assessment is reflected in the assessment of the therapist. Hall (2020) argued that, in many cases, the evaluator, in this case the therapist, has power over the patient, and typically comes from a place of privilege. According to Patton (as cited by Hall, 2020) "the very idea of being judged can induce fear" (1990, p. 49).

Kivlighan, Marmarosh, and Hilsenroth (2014) evaluated the impact of client and therapist alliance on therapy outcome using actor-partner interdependence modelling (APIM) established by Kashy and Kenny in 2000. Actor effects evaluate the relationship between predictions and outcomes from the therapist perspective while partner effects include client evaluation. The research included 74 clients receiving psychotherapy from 29 psychology doctoral students at an outpatient clinic. Consistent with Eugster and Wampold (1996), the research showed that clients and therapists take different factors into account when evaluating session effectiveness (Kivlighan et al., 2014). Kivlighan et al. (2014) also claimed that there appears to be consensus that collaboration and reciprocity are core features of the therapeutic alliance.

Clark, Canvin, Green, Layard, Pilling and Janecka (2017) utilized the data collected from the session outcome monitoring system as part of the Improving Access to Psychological Therapies (IAPT) program in the UK to evaluate treatment outcomes. The IAPT program obtained symptoms scores before and after treatment for all patients who receive at least two sessions of treatment for anxiety and depression. The patients completed a brief questionnaire after every session of treatment and the system integrated survey results, detailed information about patients, their course of treatment and clinical outcomes. This study utilized data from 537,131 patients collected in the 2014-2015 IAPT reports. The analysis found that wait times to enter treatment and number of appointments missed was negatively associated with reliable recovery rates. It also found that patients with low amounts of social deprivation showed larger improvements than patients with high social deprivation. It also showed that patients who only had low-intensity treatment (such as self-help) had low improvement and recovery rates while patients who had both low-intensity and high-intensity interventions, described as stepped care, had the highest improvement and recovery rates. The IAPT programs received data from 98% of patients and this data (without personal information) is publicly available. While one might question the

measures used to evaluate treatment, the availability of data in a centralized system, provides the opportunity for timely and accurate evaluation of treatment for a range of illnesses and patient profiles.

Online therapy and counselling have been available for decades in many parts of the world but, until COVID-19, were not broadly adopted. The summary of research that follows, suggests that online therapy and counselling can be effective but there are significant gaps in the literature that have resulted in most studies concluding that more research is needed to establish applicability and cost effectiveness. The review of this literature also helped to identify the gaps that need to be addressed in my research.

A wide range of online platforms and programs are available in Canada ranging from self-help programs, telephone counselling and therapy, group therapy delivered via a video conferencing platform and individual counselling and therapy delivered by a video conferencing platform. Dowling and Rickwood (2013) divided online services into four categories: online counseling and therapy, web-based interventions which are primarily self-guided, internet-operated therapeutic software and other online activities such as support groups. Dowling and Rickwood (2013) argued that while providing a service to every person with a mental health problem may not be feasible or appropriate, there is a need to overcome barriers, such as lack of availability of services in rural and remote areas and stigma associated with mental illness, for people who are currently underserved. The authors described the abundance of website, online support groups, online group and individual counselling, and chat rooms available to people looking for support. The authors claimed that online psychological services can be as good as services provided face to face, citing Barak et al. (2008) and others, but it is difficult for users to distinguish between various services and determine which ones may be most appropriate for them. Dowling and Rickwood (2013) also concluded that it is critical that the interventions provided are supported by research evidence. They went on to say that although there is emerging evidence supporting the use of online chat, the overall quality of the studies was judged to be poor. The research

reviewed suggested that therapist-supported interventions offered the best outcomes. My research will focus on therapist-supported interventions using telephone and video modalities.

Kunkle, Yip, Ξ, and Hunt (2020) evaluated the effectiveness of an on-demand health system for reducing depression. Data was analysed from 1662 users of a system called Ginger that is available to employees or health plan members in the U.S. Individuals excluded from participation in the Ginger system include those with risk of suicide or self-harm, a primary diagnosis of substance abuse, grave disability and certain symptoms of psychosis. The Ginger system provides coaching, therapy, and psychiatry and self-guided content and assessment primarily via a mobile app platform. The contact starts with a coach and can be escalated up to a psychiatrist as needed or requested. The system incorporates regular check-ins and feedback consistent with principles of measurement-based care. The study argued that while a significant decrease in depressed mood and anhedonia occurred more than half the time at follow-up, it stressed that these results were not generalizable to the entire user base nor a specific intervention. It also emphasized that while there is growing evidence that digital and virtual mental health interventions show promise in reducing symptoms of depression and other mental health conditions, further research is required to evaluate the features of specific technologies and the populations that use them. It is important to note that because this study was limited to employee and health plan members, the results would not apply to those without these assets.

Brenes, Ingram and Danhauer (2011) reviewed existing literature on telephone-delivered psychotherapy and explored how some of the challenges might be addressed. The paper concluded that there is high client acceptance and positive outcomes demonstrated in several studies. A meta-analysis of eleven studies on the effectiveness of telephone-based therapy determined that it can be very effective, but more research was required to establish applicability and cost-effectiveness (Haregu, Chimeddamba & Islam, 2015). According to Brenes et al, (2011), in the only randomized clinical trial available at the

time this paper was published (Lovell et al., 2006), 77% of clients in the telephone group vs. 67% of clients in the face-to-face group showed evidence of clinically significant results. While issues have been raised regarding the ability to develop a therapeutic alliance over the telephone, Mohr et al. (2005) argued that recent evidence suggests that an effective therapeutic relationship can be established in telephone-delivered psychotherapy. The question of establishing relationships online is one that will be further explored in my research.

Simon et al. (2004) found that only 29% of clients who received usual primary care were very satisfied compared with 59% who received telephone care management and psychotherapy. There was also evidence of lower rates of attrition vs face-to-face psychotherapy. The paper also argued that telehealth provides access for people who face access barriers to in-person treatment including remote location, lack of transportation, etc. It also argued that the telephone may still be a preferred method compared with computer and/or internet-based approaches due to low cost and high access of telephones. The paper suggested that a therapist's level of focus may actually increase during telephone sessions as visual cues may also be a distraction. Several challenges are documented in the paper including the therapist's lack of control over the client's environment, confidentiality and privacy, and the possibility that the client is not who they claim to be. There are also issues regarding accurate disclosure of personal information, signing of consent forms and receipt of payment where required. There are also challenges with how to deal with a crisis such a suicidal or homicidal intent. The author concludes that while more research is required, there is sufficient evidence to suggest that telephone-delivered psychotherapy can be effective for some individuals but it is not ideal for all patients and all circumstances. My research will incorporate many of the questions raised by Simon (2004), including the therapist's level of focus using online modalities and challenges regarding the client's physical environment during an online session.

Dobkin et al. (2020) found that telephone-based CBT (T-CBT was associated with significant improvements in depression, anxiety and quality of life compared to TAU in a 3-month trial comprised of 72 patients with Parkinson's Disease (PD) and major depressive disorder. Dobkin (2020) noted, however, that, on average, there was more contact in the T-CBT group than in the TAU group. While Dobkin (2020) states that more research is necessary to understand the full potential of T-CBT, it could address many of the challenges that PD patients face with limited mobility and other barriers to in-person treatment.

Gratzer (2020) provided a summary of a recent review of randomized trials that demonstrated benefits of internet cognitive behavioural therapy (iCBT). The author cautioned that iCBT must be offered as one part of an overall plan. It was also flagged that dropout rates to iCBT can be high. A brief overview on how artificial intelligence (AI) may be integrated into therapy in the future through technologies like chatbots where machines are trained to mimic humanlike behaviours and participate in conversations was also provided. Gratzer suggested that while early research has been positive, it may likely only be appropriate for some patients and some circumstances. My research further probed the issue of drop-out rates as there are conflicting opinions on drop-out rates are higher or lower using online modalities.

Gratzer (2020) also suggested that there is potential to expand programs where they do not need to be delivered by physicians or even psychologists. The author referenced the Improving Access to Psychological Therapies (IAPT) initiative in the UK and similar programs in Sweden and Norway as well as an emerging program in Ontario modelled after the UK program. Gratzer (2022) suggested that policymakers develop funding strategies that better align to needs. This is an interesting area that has been evaluated around the globe, with countries including China (Ma, 2012) having integrated non-specialist practitioners into their systems with positive results. While this idea warrants further evaluation in Canada, it was not within the scope of my research.

Ashcroft, Insua-Summerhays, and Schurter (2016) argued that online interventions widen access to people who might not otherwise receive mental health support. According to the sources cited in the article, less than 10% of patients with severe and enduring mental health problems have access to a therapist in person. Some of the barriers to access include cost, location, transportation and stigmatization. Several research studies are referenced in this article regarding the benefits and limitations of cCBT to in-person CBT. In a review of 22 studies, the authors found evidence that cCBT was as effective as in-person CBT for depression and anxiety disorders, while evidence is not consistent for other mental health problems such as OCD and psychosis. The article also argued that online treatment is more effective when there is contact with a professional. Ashcroft et al. (2016) also argued that extending treatment and education to family and caregivers improves outcomes whether they are delivered in person or online. Since caregivers and families also have issues with access (cost, transportation, etc.), telepsychiatry and online services provide many of the same benefits as patients. Ashcroft et al. (2016) concluded that more research is necessary to understand the efficacy of online therapy beyond anxiety and depression. My research will probe the type and severity of illness relative to perceived outcomes.

Cangelosi and Sorrell (2014) evaluated the benefits of technology for older adults with depression, anxiety and dementia. The authors state that older adults are more technologically savvy than we think with more than 50% of adults in the US using a computer for internet or email. The report cited research by Cotton, Ford, Ford, and Hale (2014) that suggests that retired people who use computers can reduce the risk of depression by more than 30%. The authors also claimed that Internet delivered CBT (ICBT) provides access to those who would otherwise not seek treatment because of cost, travel and mobility limitations, etc. of in-person treatment. The article cited several studies that have shown positive results of ICBT among older adults. The article also argued the benefits of technology for people living with dementia including telecare and sensors to monitor activity and movement. Some

concerns were raised including privacy as it relates to sensors and monitoring technologies and the uneven access to a computer among seniors. Given that online therapy and counselling could address barriers to in-person therapy among the elderly, and it is widely shown that they are accepting of technology, I have included questions regarding age and privacy in my research.

Significant evidence exists to show that mental health disorders can be successfully treated. There is also substantial evidence that online modalities can be effective and provide an opportunity to reach underserved populations. The challenge, evident in several sources cited, is determining which modalities will be effective for which individuals.

In summary, the literature reveals that mental and substance use disorders are highly prevalent in most countries and that a lack of funding and political will have led to a chronic gap in treatment capacity. While online therapy and counselling hold significant promise, most literature states that there is still much to learn about what works and for whom. The summary of research that follows is intended to address the gaps in the literature. In this research, therapists, counsellors and organization leaders discussed their experience with online, and compared with in-person therapy and counselling, as experienced during COVID-19 restrictions. Some of the specific questions that this research will address include how the system or therapist determines who would benefit and where online therapy would be therapeutically appropriate. It is also aimed at addressing some of the specific questions raised in the literature such as access, equity, and developing relationships online.

Research Approach

The mental health community in Ontario implemented a range of remote services to respond to the government-mandated requirement to significantly limit in-person contact, known as physical distancing. While the literature regarding the effectiveness of online therapy and counselling suggests that it can be effective in some cases, there is a need to better understand how it can be utilized effectively to augment in-person therapy or as a standalone approach. This research aims to gain a deeper understanding of the benefits and limitations of online therapy and counselling as experienced during the period of COVID-19 physical distancing to inform the integration of online therapy and counselling post COVID-19. This research was designed to build upon existing literature that occurred prior to COVID-19.

Telephone interviews were conducted with eight therapists and counsellors and nine leaders of organizations who provide mental health and addiction services in Ontario. In addition, one focus group of organization leaders, comprised of a subset of the leaders who participated in one-on-one interviews, was also conducted to further the discussion about benefits and limitations of online counselling and therapy. In order to minimize bias and ensure broad awareness of the opportunity to participate in this research study, Addiction and Mental Health Ontario (project sponsor) sent an invitation email to leaders at its 200+ member organizations. The email invited leaders to participate in the research and also asked that leaders forward the invitation to therapists and counsellors in their organizations. Interested individuals were asked to respond to me directly if they were interested. The first email solicited 14 responses. A follow up email, sent to the entire group, generated an additional three responses, thereby reaching the desired number of participants and the desired split between therapists/counsellors and organization leaders. A confirmation email was sent to all interested respondents to set up an interview

time and to request that they sign the consent form which provided specific details about the research methods, how to withdraw, and how the research would be used.

Telephone interviews commenced on August 11, 2020 and were completed on September 2, 2020. Both questionnaires were designed to be completed in 30 minutes. Most interviews were completed within 30 minutes while a few of the interviews ran up to 15 minutes over time. All interviews were audio recorded with the permission of the participants.

The therapist/counsellor questionnaire consisted of 17 questions while the organization leaders' questionnaire consisted of 18 questions. Questions were centred around their experience with online therapy and counselling during COVID-19 physical distancing restrictions. Participants described how services were provided prior to COVID-19, currently (during COVID-19 restrictions) and how they expected services would be provided post COVID-19. Participants were also asked to describe what went well and what aspects of online delivery posed challenges to the organization, the therapist and the clients (as viewed by the therapists). Organization leaders were also asked to comment on the Ontario Government's recent announcement of $3.8 billion in mental health funding and the establishment of a Centre of Excellence for Mental Health and Addiction (Government of Ontario, 2020). A combination of multiple choice and open-ended questions were included. The open-ended questions were sometimes followed up with a list of potential options to stimulate further discussion.

The online focus group took place on September 9, 2020, utilizing the Zoom platform. Six of the nine organization leaders who participated in a telephone interview participated in the focus group. The CEO and the Director, Public Policy at Addiction and Mental Health Ontario also participated in the focus group. The duration of the focus group was 90 minutes. The focus group was audio recorded to facilitate reporting and analysis.

The purpose of the focus group was stated as follows:

1. To share findings from the telephone interviews
2. To validate the interview findings
3. To identify what additional information leaders required to inform decisions about integration of online counselling and therapy post COVID-19
4. To develop a draft list of actions that stakeholders should consider in order to optimize integration of online therapy and counselling

The focus group was facilitated by me. A PowerPoint presentation was used to guide the discussion. In addition to discussing the findings from the telephone interviews, the group discussed issues and barriers to continuing with online therapy and counselling post COVID-19. The group also discussed larger system issues that impact their ability to serve clients effectively. A list of draft actions was also discussed to help guide what could be next steps following the conclusion of this report.

Research Results

The analysis of the data collected in the interviews utilized an inductive approach to the research. Themes were established based on the comments that emerged most frequently and the comments that generated the most significant concern or discussion. The focus group utilized a deductive research approach by presenting the key findings from the interviews and allowing participants to build upon the telephone interview findings.

Themes Mentioned Most Frequently in Interviews

Convenience and flexibility were mentioned by 16 of 17 research participants (94%). This included convenience for both the therapists/counsellors and the clients. For therapists, working from home meant better work/home balance as it eliminated the travel time to and from work and for some, it also eliminated travel time to see clients at their homes. For clients, it meant not having to take as much time off work to attend therapy, not having to navigate bad weather or poor transportation options. For both, it provided more flexibility in scheduling appointments, providing more options and fewer restrictions.

Access was mentioned by 16 of 17 interviewees (94%) but perceptions were mixed. A total of eight interviewees (47%) perceived access to be better since people living in remote areas, housebound by physical or mental illness, without transportation, or unable to get necessary time off work or away from family were able to access online support. Conversely, four of 17 interview participants (24%) perceived access to be reduced for a number of reasons: clients that did not have access to technology, clients were homeless and therefore visiting the clinic was their only way to access support, and clients were unable to find a safe and/or private space to participate in online treatment. A total of three participants (18%) mentioned a combination of positive and negative experiences with regards to access

to treatment. In some cases, a client who lived remotely or had transportation challenges would attend therapy more regularly when offered online. In other cases, such as a homeless person without a telephone or computer, would have no access to therapy if online was the only option. In a study conducted by Fikretoglu & Liu (2014), it was reported that 16.9% of new onset cases reported unmet needs with access listed as one of the key barriers.

Impact, described as the ability for the therapy delivered online to have a positive impact, was mentioned by 15 of 17 participants (88%). Of the 15 participants who mentioned impact, 12 described mixed results. While a number of possible reasons for the differences in impact were discussed, including age of client and having established a relationship in person prior to online therapy, most described the reasons to be associated with the mental illness and other health-related factors. For instance, some clients with social anxiety were more receptive to therapy in their own homes than in a clinic environment. For others, there was a positive impact because their attendance improved. Conversely, some clients became worried or paranoid that they were being watched or listened to by others. Also, many clients who had experienced trauma needed someone to physically hold space for them in order to make progress. There were also numerous references to silence and physical cues being important parts of the therapy process and yet, silence felt awkward online and was very difficult to comprehend by phone and visual cues such a toe tapping or hand wrenching were not visible. A lack of privacy or perceived lack of privacy also impeded results with several therapists and counsellors sharing that clients worried that family members or roommates could hear the conversation. Some also worried about who, other than the therapist, had access to the session during or after it ended. This finding is supported by Norcross & Wampold (2011) who argued that in order for therapy to be effective, it needs to be adapted to the specific patient. Kunkle, Yip, Ξ, & Hunt (2020) also argued that while there is growing evidence that digital and virtual mental health interventions show promise in reducing symptoms of depression and

other mental health conditions, further research is required to evaluate the features of specific technologies and the populations that use them.

Efficiency and cost savings related to online therapy and counselling were mentioned by 12 participants (71%). These respondents perceived a positive relationship between efficiency/cost savings and online treatment. For therapists and organizations, reduced travel costs were frequently cited as a benefit. Also, less travel time resulted in the ability to see more clients in a typical day, increasing efficiencies. In some cases, organizations were able to hire more therapists and counsellors without needing more office space. According to Clark, Canvin, Green, Layard, Pilling & Janecka (2018) efficiency can be correlated with improved treatment outcomes. Clark et al. (2018) reported that wait times to enter treatment and number of appointments missed was negatively associated with reliable recovery rates so more therapists or the ability of a therapist to see more clients could lead to more positive treatment outcomes. For clients, online therapy also resulted in reduced cost of travel to and from appointments and parking at appointments. For some, it also meant not having to take as much time off work to attend therapy. It was also frequently mentioned that online sessions were more likely to start on time and finish on time or early. These barriers are supported by Fikretoglu & Liu (2014) whose analysis showed that 16.9% of new onset cases reported unmet needs with issues such as family responsibilities and taking time off work being factors affecting unmet needs.

A total of 11 participants (65%) raised the issue of equity with nine of the 11 who mentioned equity (82%) citing online as negatively associated with equity and two participants providing a mixed view. No participants positively associated online therapy and counselling with equity. The central concern shared was that decisions about online vs. in-person treatment when there was a choice (pre-COVID and post-COVID) would more often be made based on convenience or cost versus what was therapeutically most appropriate. A study by Clark et al (2018) found that patients with low amounts of

social deprivation showed larger improvements than patients with high social deprivation. It also showed that patients who only had low-intensity treatment (such as self-help) had low improvement and recovery rates while patients who had both low-intensity and high-intensity interventions, described as stepped care, had the highest improvement and recovery rates. Brenes, Ingram & Danhauer (2011) also argued that while more research is required, there is sufficient evidence to suggest that telephone-delivered psychotherapy can be effective for some individuals but it is not ideal for all patients and all circumstances. An example regarding equity that was shared was that people living in remote communities, where no in-person therapy or counselling was available, had no choice but online therapy. Participants shared that online therapy was sometimes positioned as a suitable solution for people living in remote communities, providing the rationale that no other solutions were feasible, regardless of whether or not it was therapeutically appropriate for that individual. Ashcroft, Insua-Summerhays, & Schurter (2016) argued that while online interventions widen access to people who might not otherwise receive mental health support, more research is necessary to understand the efficacy of online therapy beyond anxiety and depression. Another consideration tied to equity was whether or not the client had a family physician. As one organization leader stated, “somebody needs to have eyes on the client. With no “eyes on the client” physical changes such as weight loss or even a change in cleanliness could go unnoticed, impacting the client’s mental and physical health. The other equity-related issue commonly raised was with regards to access to and ability to use technology. Participants shared that those who are most marginalized would not have equitable access to therapeutically appropriate care if only online therapy was available to them.

Of the 11 participants (65%) who mentioned the effectiveness of the technology itself, only one person mentioned having no issues with the technology. The issues mentioned most often was the reliability and stability of online video platforms. Challenges were most often a result of insufficient bandwidth and poor internet connectivity.

All but one therapist/counsellor talked about their ability to develop a trust relationship online. This was only mentioned by one organization leader given that they are not typically interacting with clients. Six of the seven therapists/counsellors (86%) who mentioned relationship building perceived the experience online to be mixed. For some clients, being in their own home made them more relaxed or feeling more in control and therefore more trusting. There was also a sense, in some cases, of being "equals" when both therapist and client were in their own homes and experiencing some of the same challenges such as a barking dog or a technology glitch. Eugster & Wampold (1996) reported that, according to patients, session evaluation was best predicted by the therapist real relationship. These results suggested that when a patient is being related to in a manner that appears more personal and caring, he or she evaluates the session positively. This would include subtle cues like authenticity and the sense that the therapist is willing to be perceived and related to as a person within the context of a genuine human relationship. Many therapists who were providing support by phone mentioned clients' willingness to open up more on the phone, possibly because the interaction felt more social or casual than an in-person therapy session. According to Brenes et al. (2011) evidence suggests that an effective therapeutic relationship can be established in telephone-delivered psychotherapy. In some cases, however, therapists found it difficult to develop relationships online. The reasons most often mentioned included the client's discomfort with the mode, client not wanting to see themselves on the screen and low digital literacy. For some clients, it was difficult to build trust with someone they had not met face to face, especially if they were not using online platforms for other purposes. A study conducted by Simon et al (2004) reinforced the challenges sometimes experienced including the therapist's lack of control over the client's environment, confidentiality and privacy, and the possibility that the client is not who they claim to be.

Organization leaders were asked about their perspectives on the recent Government of Ontario announcement of $3.8 billion investment in mental health and addiction and the establishment of a

Centre of Excellence to lead the implementation of several strategies outlined in the announcement. They were asked if they supported the Government's direction and if they were hopeful about the outcomes. Of the nine responses to the question, four (44%) were mostly negative, three were mixed (a combination of positive and negative), one was neutral, and one was positive. Most raised a concern that the Government had not consulted with the community in developing its plan. Many raised concerns that chronic underfunding of system (Mental Health Commission of Canada, 2017) had resulted in a patchwork approach vs an integrated plan they did not see that changing. Some raised concerns that the Government was mostly concerned about providing services to the vocal and influential white-collar middle class and that their plans to date did not adequately address marginalized communities. Some also expressed concern that investments would likely favour online therapy and counselling because of the perceived cost-effectiveness and that cost-intensive programs such as residential programs would continue to be under-funded.

While other issues such as age, training, safety, and continuity were probed, these did not emerge as significant themes.

Focus Group Findings

While no new themes emerged in the focus group, the topics that generated the most discussion were related to equity and the ability to determine if treatment, whether online or in person, was having an impact.

In terms of equity, several participants perceived the current system and the priorities for investment to not be based on principles of equity and inclusion. Knaak, Livingston, Stuart, and Ungar (2020) supported this perspective in a recent report which argued that there is structural stigma in the mental health care system. In this report, structural stigma is defined as the activities of systems and organizations that create and maintain social inequities, both deliberately and inadvertently. Knaak et al.

(2020) claimed that there is an inequitable distribution of resources for mental health and substance use, insufficient resources in many areas, and a lack of focus on recovery principles. It suggested that those with mental health and substance use are treated unfairly and that the more stigmatizing attributes that a person carries, such as unemployed or overweight, the more inequitably that they are treated. The report also claimed that the effects of stigma are worsened when other forms of oppression exist including racism, sexism, classism and homophobia (Knaak, Livingston, Stuart, &Ungar, 2020). This existing system of stigma and bias fueled concern among research participants that online therapy and counselling could be used as a cost-effective way to respond to marginalized communities, regardless of what might be deemed therapeutically appropriate. They also reinforced the linkage between mental and physical health and the increased challenge when there is no family physician in place. A report by Mental Health Commission of Canada (2017) reported that a clear relationship between social determinants of health, including food insecurity, poverty, and poor access to healthcare and likelihood of developing a mental health problem.

Participants also stressed the need for clear standards and protocols to inform when online treatment would be most suitable. This suggestion is reinforced by Canadian Institute of Health Information (2019) which stated that 30% of primary care physicians reported seeing patients with substance abuse issues and 51% reported seeing patients with severe mental health problems but only 15% and 23% respectively felt prepared to care for those patients. Concerns with when and how online therapy is used was reinforced by Dowling & Rickwood (2013) who argued that it is critical that the interventions provided are supported by research evidence.

Participants also stated that caution must be used when evaluating what was done in a crisis when in-person treatment was not an option and expectations from the system had changed and apply that experience to a post-COVID environment.

Barriers and Limitations

I chose to limit research participation to member organizations of Addiction and Mental Health Ontario to achieve a high likelihood that respondents to the request would be qualified to participate. While a broad social media recruitment approach was considered, it was rejected because it would have required a time-intensive stage of qualification and potentially a large number of refusals based on not meeting criteria. While 220 organizations provided a sizeable base to draw from, there was still concern that a sufficient number of expressions of interest would not be received, especially given all of the changes and new challenges that organizations were experiencing as a result of COVID-19. Had an insufficient number of responses been received, a broad social media invitation would have been implemented.

The most significant limitation of this research is that its findings are based on the opinions of participants versus using an objective measurement tool to determine benefits, limitations and outcomes. The other limitation is that the research investigated benefits and limitations during a crisis. In a crisis, priorities are different with an emphasis on maintaining service versus maximizing outcomes. This limitation was considered and effort was made in the questionnaire to separate the current situation with what might work in the future, post COVID-19 when physical distancing was no longer an issue.

The most significant gap in evaluating the effectiveness of online therapy and counselling is the lack of data and outcome measurement. A working group headed CIHI that including the federal, provincial and territorial government representation reported that existing measurement and reporting across the country was mainly associated with hospital care, with little to no measurement available on community care including access and client outcomes (CIHI, 2018). Bullock & Lavis (2019) also reported that, unlike other areas of healthcare in Canada, a significant portion of services is delivered by private, for-profit providers, where service delivery decisions are made by operating boards vs. government.

While, according to CIHI (2018), a system is in development, concern was expressed in the interviews with organization leaders regarding the resources required to implement a measurement system and the time it would take away from client care. There was also an argument made that until significant investments are made in front line care resources, there are limited benefits in measuring a system that is not working. Bullock& Lavis (2019) also argued that because of the complexity and fragmentation of the system, it is challenging to achieve systemic change.

I would like to share my appreciation of the generosity of participants; their willingness to share their time during an incredibly busy period; provide thoughtful and valuable insights, often using specific examples to illustrate a point; and provide me with additional resources and scientific evidence to consider.

Discussion

In large part, the research findings were consistent with the findings in the literature reviewed. The research also addressed several of the gaps identified in the literature and brought deeper clarity to many important issues such as equity, access, convenience, and the importance of the relationship between therapist and client.

The research, consistent with the literature reviewed, concluded that online therapy and counselling can be effective for some people and in some situations. The research provided valuable insight into who would be most likely and who would be least likely to benefit, based on their experience during COVID-19. On the one end of the spectrum, those who may be most likely to benefit from online modalities include individuals with early onset mild depression or anxiety with a stable support system at home. It may also be effective for individuals with chronic disease and mobility challenges, such as advanced Parkinson's Disease, where in-person treatment of associated depression or anxiety would not be possible. It could also benefit individuals on wait lists for more intensive care or as a step-down from intensive inpatient or residential care. On the other end of the spectrum, individuals who have experienced trauma, have suicidal tendencies, are low functioning, or do not have a stable home environment or support system would be less likely to benefit from online therapy or counselling.

Much of the literature described an under-funded, fragmented, and stigmatized system. Interview and focus group participants provided similar descriptions as well as greater clarity on the severity of the impact for both the providers and clients. Issues like the lack of beds for inpatient care, long wait lists, lack of resources, and lack of funding, were frequently mentioned. Research participants also shared that, because the system was not built on principles of equity and inclusion, it was difficult to expect that future investments would be aimed at providing equity with other healthcare systems or equity across socioeconomic groups within the mental healthcare system. Research participants

frequently raised this concern and suggested a bias favouring the middle class over lower income or marginalized individuals who tend to experience mental illness more frequently.

The research also supported the literature in recognizing the benefit of convenience of online modalities for both therapists and clients and raised similar caution about valuing convenience and cost-effectiveness over therapeutic appropriateness. For clients who could not take time off work or find childcare to attend an appointment in person, an online option was highly valued and therefore might be the best option for that client. However, several participants worked at organizations that were expected to serve a large, physical geography within Ontario where some clients would be required to travel several hours for an in-person appointment. In these situations, the client did not really have an option of in-person treatment, regardless of therapeutic needs. This is one example of the inequity in the mental health system that exists to a much lesser degree in the rest of the health system.

Given my experience in the corporate sector, where metrics, to a large extent, direct decisions or at least justified them, an observation here is the lack of results measurement in therapy and counselling. This lack of measurement could be a major deterrent to additional government investment and yet, I perceived a resistance to implementing more robust measurement systems and tools. This is a complex and multi-layered topic that I will not attempt to do justice to here but I think it is important to highlight the concerns: time spent on evaluation could take time away from resource constrained client-facing work; participants would rather that funding went to front-line resources versus measurement systems; many therapists and counsellors perceived that they are forced to under-treat patients in many cases due to resource and funding issues so measurement results might well be disappointing; and because relationship play such an important role in the therapeutic experience, an outcome in one case may not be translatable to another similar case. Also, as argued by Miller (2020), current evaluation models may not be the most effective. Miller (2020) argued that a contextual model would be more effective as it

involves consideration of factors such as culture, location, and the person(s) involved. A contextual model would also consider whether a particular therapist is a fit for the patient, depending on contextual considerations.

Despite challenges, the ability to deliver therapy and counselling online offers immense opportunity to improve access, increase cost-effectiveness, and ultimately provide services to more individuals who require them.

Recommendations

The seven recommendations that follow have been informed by my research who have been providing therapy and counselling online as a result of COVID-19 physical distancing restrictions and previously provided therapy and counselling in-person and supported by an extensive review of relevant literature. The recommendations aim to offer opportunities to improve the mental health and addiction system in the short, medium and longer term.

Short Term Recommendations (within 12 months)

1. A working group (potentially comprised of AMHO member organizations) be established to leverage the extensive learning during COVID-19 to create draft guidelines for using online modalities. The group would also advocate for adoption of guidelines across the province as a short-term measure to guide transition to a blended model of care, post COVID-19.
2. Invest in further research to prove out specific and measurable scenarios with highest likelihood of effectiveness and lowest likelihood of effectiveness to further support and refine guidelines.

   Highest likelihood of effectiveness scenarios would include:

   - Individuals with mild early onset anxiety and depression and a support system in place
   - Individuals on wait list for residential, inpatient or other intensive in-person treatment
   - Individuals who successfully completed intensive treatment and are returning to a safe and supported environment
   - Individuals with frequent contact with family or specialist physician for other illnesses

   Lowest likelihood of effectiveness scenarios would include:

   - Lowest likelihood of effectiveness
   - Individuals who have experienced severe trauma
   - Individuals who are low functioning
   - Individuals who do not have access to a private space
   - Individuals who are socially deprived and/or have no support system in place

Medium Term Recommendations (12 months to 3 years)

3. College of Family Physicians or alternate appropriate body to provide training to family physicians to ensure that they have the skills and knowledge required to better serve mental health and addiction patients from diagnosis to treatment to specialist referral. Given that, for many, the family physician is the first point of contact, and often the only available resource, this would increase capacity and effectiveness of the current system.
4. Government to acknowledge that online modalities are not "the" solution for remote and rural communities and prioritize increasing resources (psychologists, psychotherapists, counsellors, case workers, etc.) in under-served communities, building upon the existing technology-enabled heath hub model. Specific targets must be set and timeframe established to reach this target.
5. Government to recast its plan, announced in March 2020, by socioeconomic sector. This would start the process of system repair and integration from the perspective and journey of the patient and ensure that equity issues were visible and being addressed. Each sector plan would include an online component but when, where, and how these services were offered would likely vary significantly by sector. Examples of sectors would be homeless adults living in urban communities; homeless adults living in rural or remote communities; middle to upper income adults living in urban communities; or youth living in remote communities.

Longer Term Recommendations (3 years +)

6. Based on community feedback on draft guidelines and further research as recommended above, a more comprehensive set of guidelines for use of telephone-based and video-based therapy and counselling to be developed for province-wide adoption and shared with other provinces and potentially other countries.

7. Government and community work together to develop a set of measures to evaluate the effectiveness of both online and in person therapy and counselling. This set of measures will not only help government to determine investment priorities and set expectations for results from investments, it will help the community determine where improvements in front line treatment can be made. It may also provide a common language so that government and community are able to work together more effectively.

Conclusion

The aim of this project was to investigate the effectiveness of online therapy and counselling during the period of COVID-19 physical distancing to inform how the healthcare system might integrate online therapy and counselling post COVID-19 most effectively. Prior to COVID-19, adoption of online modalities was low as the need for change was not sufficient to stimulate wide behaviour change, despite growing evidence. With the vast majority of mental health and addiction care providers having now moved to online modalities in Ontario, this research provided unprecedented, valuable and timely learning. It is with caution, however, that we determine the way forward.

The research supported the literature in concluding that online therapy and counselling can be very effective for some individuals in some circumstances. It also filled some of the gaps and inconsistencies in the literature regarding who would be most likely to benefit and who would be least likely to benefit. Concerns with benefits such convenience and lower delivery cost taking precedence over therapeutic effectiveness are of major concern and lack of effective measurement makes the argument to maintain and invest in community-based therapy and counselling more difficult.

These research findings provided the groundwork to develop a set of guidelines for implementation post COVID-19. These guidelines will be critical in guiding the transition back to a blended model of delivery and it is recommended that the development of these guidelines be led by the community, where the deep knowledge and experience from the last nine months resides.

It was difficult to look at online modalities in isolation given the many challenges that the mental health and addiction system faces. Government and non-government stakeholders must work together to rebuild and repair a mental health care system that all agree is underfunded,

disconnected, and highly stigmatized. While the Government of Ontario has acknowledged the need for investment and its plan announced in March 2020 includes many of the priorities identified in this report, there is concern that the government's plan does not fully address the significance of the gaps or the level of inequity in the system, and that the government is making decisions in isolation or with very limited consultation. It is also imperative that the voices of those with lived experience are included in this discussion as we cannot even begin to place ourselves in their position from our place of power, privilege and well-being.

In closing, online therapy and counselling provides significant opportunity to improve access, increase efficiencies, and reduce barriers but its integration must be carefully and cautiously planned to ensure that care is improved for all and not improved for some and reduced for others. It is my hope that the learning and recommendations in this report help to pave a way forward that is grounded in evidence, supported by the community, and can make a positive difference in the lives of the millions who suffer with mental health and addiction in Ontario, the rest of Canada, and around the world.

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