EXPANDING ACCESS TO PUBLICLY-FUNDED PSYCHOTHERAPY: A COMPARATIVE POLICY ANALYSIS IN ONTARIO AND BRITISH COLUMBIA

BY KATHERINE LEE, B.A., MPPA

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Abstract

In 2021, Ontario became the first province in Canada to adopt a provincial publicly funded psychotherapy program, after a three-year long pilot project (2017-2020). Meanwhile, more than a decade prior, in 2008, British Columbia introduced a smaller-scale program, Bounce Back, but opted to not adopt a larger-scale provincial program. This dissertation investigates the development of publicly funded psychotherapy in Ontario and British Columbia through a comparative policy analysis of mental health policy reform.

Broadly, this dissertation asks: "Under what conditions do jurisdictions achieve mental health reform?" More specifically, it addresses two sub-questions: 1) What conditions allowed British Columbia to adopt an early, low-intensity program and then constrained it from adopting a larger-scale program? 2) What conditions limited early policy development in Ontario, but allowed for a more ambitious and larger-scale program more recently?

Amid the rising demand for affordable and accessible mental health care services across Canada, both provinces adopted community-based mental health models of care oriented around cognitive behavioural therapy. This dissertation draws on four well-established theoretical frameworks in political science: ideas, institutions, policy learning, and policy entrepreneurship, to analyze and explain Ontario and British Columbia's divergent mental reform trajectories.

Empirically, this research draws on extensive qualitative methods, including documentary analysis and over 30 elite interviews with policymakers, healthcare leaders and providers. These interviews offer insider perspectives on the motivations, challenges, and strategic decisions behind the policy decisions each province made. The findings highlight key differences in the policy processes and contextual factors that led Ontario to adopt a UK-inspired provincial program through the Ontario Structured Psychotherapy Program, in contrast to British Columbia's decision to implement a smaller-scale, low-intensity program, Bounce Back.

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Last but certainly not least, to the 1 in 5 Canadians who personally experience a mental health illness: this dissertation is dedicated to you. I promise to continue to advocate on your behalf for better mental health policies and programs - whether it is through research or within the workplace. You're the reason for this research.

CHAPTER 1: INTRODUCTION

Background

The Canadian Mental Health Association (CMHA) defines mental health as a "state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community." Mental health has been long recognized as a fundamental aspect of one's health, however, under our current healthcare regime, the majority of mental health services in Canada are not publicly funded or universally accessible. Unless received in the hospital, psychological services are paid for out-of-pocket or alternatively, for those who qualify, by a private third-party insurance (McPhail, 2017). With the burden of paying for one's own mental health needs falling on the individual, it is unsurprising that the lack of accessibility to mental healthcare in Canada has been referred to as a "silent crisis" (Peachey et al., 2013). Canadians collectively spend $950 million annually on private psychotherapists for mental health illness, while 30 percent pay out-of-pocket (CMHA, 2018). The overall result is that Canadians spend $1B for private counselling and psychotherapy every year (CMHA National, 2023).

The Mental Health Crisis

The Mental Health Commission of Canada (MHCC) states that 1 in 5 Canadians will experience mental health challenges every year with mild to moderate forms of anxiety and depression being the most common mental health disorders (2017). However, only 1 in 3 individuals suffering from illness report seeking treatment (McPhail, 2017). In addition, a 2018 Canadian Community Health Survey found that 43.8% of those Canadians reported "unmet or only partially met" mental healthcare needs. These numbers were higher within the individual provinces of Ontario and British Columbia respectively than in the rest of the country: with 46.1% of those surveyed reporting unmet needs in Ontario, and 51.1% in British Columbia (Government of Canada, 2019).

The stark nature of the scope of the mental health crisis in Canada as detailed by the number of individuals who can be expected to suffer from mental health concerns only tells us part of the story. There are also human, workplace and broader economic dimensions as well

that provide a greater understanding to the extent of the crisis. At the personal level, suicide is the leading cause of death among youth and younger adults between the ages 15-34 (Public Health Agency of Canada, 2022). According to the Public Health Agency of Canada, approximately 12 people die by suicide each day, which amounts to approximately 4500 deaths per year (Public Health Agency of Canada, 2022). Provincially, the rate for Ontario is 11.5 deaths per 100, 000 per year (CBC, 2023). Beyond the human suffering costs, there are also broader societal impacts of the continuing mental health crisis. For example, the Mental Health Commission of Canada reports that the stigma surrounding mental health costs employers an additional $20 billion dollars per year, as lack of access to mental health services and unfriendly work environments (which do not allow for open discussions regarding mental health) lead to employee absences, loss of productivity, and rising disability and other healthcare related claims among employees (MHCC, 2018). In workplaces, psychological problems make up nearly 70 percent of disability costs. This is only the workplace – the Canadian economy as a whole experiences a burden of $51 billion per year. This includes healthcare costs, loss of workplace productivity, and reductions in health-related quality of life (CAMH, n.d.).

Despite this burden and impact, mental health concerns, at least until more recently, have failed to capture the priority attention of Canadian governments. For example, the Canadian federal government only allocates 5-7% of total spending of their healthcare funding towards mental health. This statistic is reflected in one of Canada's largest healthcare systems, Ontario, whose overall healthcare spending towards mental health and addictions is only at 7% (CAMH, 2023). Evidently, this is not a sufficient amount when mental illness in Ontario accounts for 10% of the burden of disease (CAMH, 2023).[1] The province's goal was to increase the level of funding dedicated to mental health to 9% by 2022, as Ontario's mental healthcare was underfunded by at least $1.5B as of 2018, yet this has still not been achieved (Bartram, 2018; CAMH, 2023). Canada trails behind other OECD countries who spend as much as 18% of public health spending on mental health, with UK allocating 13% of total health spending to mental health (Bartram, 2018; OECD, 2012).

[1] Burden of disease is a concept that was developed in the 1990s by the Harvard School of Public Health, the World Bank and the World Health Organization (WHO) to describe the death and loss of health due to diseases, injuries and risks factors for all regions of the world.

The lack of commitment towards mental health care as compared to physical health and its overall lack of correspondence to the scope of the mental health crisis is also highlighted by the lack of treatment options and the lack of accessibility to treatment in Canada. Until the mid to late 2000s, in Canada, there was an overall lack of attention provided to the mental health sector particularly through community-based care, as was evident in the need for the establishment of the Senate Committee on Mental Health and the ensuing Kirby Report (Kirby & Wilbert, 2006). Mental healthcare services such as psychotherapy were offered primarily through private practice, unless they were offered through a physician or hospital-based setting.

The Research Puzzle

This dissertation explores the broad question of "Under what conditions does policy change occur?" It investigates and seeks to understand policy change both in terms of the timing of when governments choose to act as well as the scope of their policy responses. It examines the response of two Canadian provinces, Ontario and British Columbia respectively, who made different decisions in their mental health reform efforts to address the mental health crisis in Canada, including and the lack of access to publicly funded psychotherapy.

In May 2006, the Government of Canada launched the country's first ever national report on mental health *Out of the Shadows at Last*. Also known as the "Kirby Report," this report was the "most comprehensive study of mental health in Canada (Kirby & Wilbert, 2006)." Not only did this report push mental health onto the national agenda and call for mental health reform in Canada due to the severe lack of access to mental health services available for Canadians seeking mental health care, it also shifted the priority in mental health care onto less severe forms of mental illness, including anxiety and depression. The report also noted that the lack of access to publicly financed mental health services, which were treated primarily by pharmaceuticals and some forms of talk therapy and usually offered primarily by family physicians and psychiatrists, resulted in long wait times. This left only one other alternative for individuals seeking mental health services: the private system – which could be accessed by paying out-of-pocket or through coverage provided through employer-funded workplace benefit plans for those fortunate to have such coverage. However, the lack of universal and publicly funded access to mental health care meant that many Canadians would not be able to seek

mental health support. Hence, the Senate Report called for a mental health reform which would be "recovery-oriented, person-centred and predominantly community-based" (Kirby & Wilbert, 2006).

Many provinces echoed the sentiments expressed in the Kirby report, but British Columbia took the initiative. In 2007, the BC Ministry of Health allocated $6M in funding to the Canadian Mental Health Association - BC Division to explore the possibility of expanding access to community-based mental health treatment programs. As a result, and following that experience, in 2008, the province formally created *Bounce Back*, a low intensity cognitive behavioural therapy (CBT) program, to provide publicly funded and widely available psychotherapy support to British Columbians. As a key motivator and purpose, the program was created with the intention to relieve the increasingly overwhelming burden on family physicians of providing psychotherapy services as part of their practices and to meet the increasing demand for mental health support in the public healthcare system, particularly those suffering from chronic and less severe illnesses. As a key element of the design of the program, Bounce Back offers low-intensity cognitive behavioural therapy in which the delivery of psychological support services is primarily accomplished through online, self-directed workbooks, and phone calls with a coach. In this case, British Columbia represents an "early and small" policy change, with small being defined as that it was not comprehensive as it only offers low-intensity programs.

In contrast, there was not much movement in Ontario to increase access to universally available and publicly funded psychotherapy until 2017 when the provincial government announced the launch of a three-year province-wide publicly-funded psychotherapy pilot project, *Increasing Access to Structured Psychotherapy (IAS*P). In 2020, this initiative transitioned into a full-fledged program, *Ontario Structured Psychotherapy Program (OSP).* As a result, Ontario became the first province in Canada to adopt a province-wide publicly funded psychotherapy program, making available a mixture of both low and high intensity CBT services to all Ontarians. The difference between Ontario's program and that of the one implemented by BC is in the availability and the scope of intensity of psychological counselling services – moving from simple coaching in BC (and delivered usually over the phone or online) to more traditional

forms of in-person counselling in Ontario. In this case, we can describe Ontario's policy change as "late and big", having adopted a much more comprehensive and publicly funded program, offering a mixture of both low and high intensity services, and which mirrored the UK's nationwide program.

I argue that the reason for the difference in the policy changes that took place in terms of the scope of psychological services available and the timing of their inclusion into the provincial health care schemes within my two Canadian case studies is due to, in part, the changing nature of ideas on mental health – ideas associated with:

- the nature and/or prioritization of mental illnesses,
- the appropriate types of treatments and
- the appropriate types of treatment providers.

Ontario and BC, who both faced similar mental health crises during a similar period were, in part, faced with the changing ideas of mental health concerns, moving from a relatively exclusive focus on severe mental health illnesses to ones including the need for treating mild to moderate mental health disorders such as anxiety and disorder. Coinciding with this overall reorientation of the mental health space, there were changing ideas towards the appropriate types of treatment and the appropriate types of treatment providers: from institutionalization and prominence of the medical model to community-based mental health programs.

In Ontario, these changing ideas associated with treatment and treatment providers and the corresponding focus on less severe forms of mental illness were responsible, in part, in overcoming the medically dominated community to include a wide range of healthcare actors, particularly when coupled with external influences and learning from the UK. In contrast, in the case of BC, these more highly contested ideas of priorities, treatments and treatment providers were less successful in being able to overcome the province's entrenched and more highly contentious interests concerning psychological services and service providers and an ongoing shift in priorities of mental health concerns.

Against these shifting ideational backdrops, another key part of this story is the entrepreneurial roles and successes undertaken by healthcare leaders in both provinces. In Ontario, well placed policy entrepreneurs played a strongly influential role in the change in

ideas regarding the effectiveness of non-prescription mental health treatments, and the necessity for inclusion of CBT therapy, as well as who should provide mental healthcare services. In BC, after the initial success with the establishment of a low intensity program that did not involve the need for traditional psychotherapy services, there was an absence of such positive acting entrepreneurs with either the access or ability to promote a broader and more comprehensive approach to mental health treatment and support in the province. Thus, ideas appear to play a necessary role in the policy change in both of my case studies. However, those ideas alone were not sufficient in achieving large scale change, as evidenced in BC. Instead, in both of my case studies, we observe that it was the role of ideas coupled with the presence of entrepreneurs which drove the larger and more comprehensive change in Ontario and which were more absent in BC after the initial and smaller policy change.

An Overview of Canada's Healthcare System

While traditionally and historically considered to be a policy space belonging at the provincial level, more modern considerations of the healthcare system in Canada are less clear and result in a shared area of responsibility (Blankenau, 2010). On this front, the Canada Health Act (CHA) is Canada's federal legislation that undergirds and provides for a publicly funded healthcare insurance system. The CHA sets out the primary objective of Canadian health care policy "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" (Government of Canada, 2011).

Despite the seeming lack of jurisdictional clarity, the role of the federal, provincial and territorial governments in the delivery and administration of healthcare differs substantially. The federal government is responsible for:

- Setting and administering national standards for the healthcare system through the CHA
- Providing funding support for provincial and territorial healthcare services
- Supporting the delivery for healthcare services for specific groups
- Providing other health-related functions. (Government of Canada, 2011):

- Regulations of products (i.e. pharmaceuticals, medical devices etc.)
- Health research
- Health promotion and protection
- Disease monitoring and prevention
- Health-related costs:
    - Tax credits for: disability, medical expenses, and caregivers and dependents
    - Tax rebates to public institutions for health services
    - Deductions for private health insurance premiums for the self-employed

Overall, and despite the range of roles provided under the CHA, the federal government's primary responsibility is as a funding provider to the provincial and territorial governments and for the purposes of enabling a minimum standard of care across the country (Maioni, 2002). As part of that funding role, the CHA sets out the conditions and criteria related to "insured" health services and extended healthcare services that provinces and territories must provide to receive the full federal funding allotment under the Canada Health Transfer (CHT).

The overall and general delivery of most healthcare services, on the other hand, remains the responsibility of the provinces and territories. However, the provincial and territorial healthcare insurance plans must meet the standards in the CHA or risk losing some level of funding under the Canada Health Transfer payment from the federal government. These standards include:

- Public administration
- Comprehensiveness
- Universality
- Portability
- Accessibility (Government of Canada, 2011).

Comprehensiveness is particularly important to note as provincial and territorial plans must insure all "medically necessary" services provided by:

- Hospitals
- Physicians

- Dentists, when the services are performed within a hospital (Government of Canada, 2011).

However, despite the existence of this condition as a precursor to eligibility for federal funding," medically necessary" services are not defined within the CHA. Instead, provincial and territorial governments must decide which services to cover under their healthcare insurance plans, usually after consultation with their respective physician colleges and other relevant medical professional or service provider groups. Together, they are responsible for deciding which services are medically necessary for healthcare insurance purposes. Once a treatment or healthcare service is deemed 'medically necessary,' the full cost of the services must be covered by the public healthcare insurance plan.

The determination as to the scope of medically necessary services that had to be covered by provincial health insurance plans was not, however, frozen with or at the time of the introduction of the Canada Health Act. Rather, provincial and territorial governments are free to decide on new programs that involve the delivery of healthcare or healthcare related services and to fund those treatments or services with public dollars. In those circumstances, it is entirely within the discretion of the provincial government to decide what types (and scope) of treatments and services and which treatment and service providers are eligible for funding without repercussion on their eligibility under the CHT. And while neither province moved so far as to designate psychological counselling services as a "medically necessary" service (unless provided by a physician or within a hospital) as a response to the mental health crisis in the country, it is against this backdrop that the changes in mental health approaches within BC and Ontario become clearer.

Ideas and the Mental Health Policy Space

As in the broader health policy sphere, there are a number of issues and concerns that provide a general context in which more specific policy decisions are made, and programs are implemented and administered in the mental health policy space. This potential for a range of ideas and issues make up one component that would mark mental health policy as a complex or complicated policy environment (Peters & Tarpey, 2019). Three of these more prominent and

interrelated concerns revolve around ideas associated with the types and prioritization of illness(es), the relevant types of treatments and the relevant range of possible treatment and service providers.

1. Types and Priorities of Mental Illness

(a) Severe Mental Health Illnesses (SMI): There is both no universal definition of and a lack of consistency over how SMIs are defined in practice. **The National Institute of Mental Health (2019) defines SMI as "a mental, behavioural, or emotional disorder resulting in serious functional impairment."** In the earlier literature which places a significant focus on SMI, such as Ontario's first-ever comprehensive mental health report, the Graham Report (1988), they provide examples on those with SMI as individuals dealing with schizophrenia or psychosis. Thus, in the early mental health literature, unless it is clarified which mental health disorders they define as SMI, it can be assumed that the literature considers it an umbrella term referring to chronic psychiatric disorders such as psychotic disorders (i.e. schizophrenia) or personality disorders (i.e. bipolar disorder). However, current and more recent existing literature acknowledges that there is a spectrum for mood disorders as well – such as major depression and anxiety disorders, which can significantly limit a person's ability to function in their daily life.

(b) Mild to Moderate Mental Health Conditions (i.e. anxiety and depression)

Building off the previous point, there are different degrees of severity of anxiety and depression, and my dissertation specifically focuses on treatment for those with mild to moderate forms of mental health concerns, specifically, mood disorders such as anxiety and depression. Mild to moderate mental health conditions are less severe than severe mental illnesses, and while symptoms can be managed through medication and/or psychological therapies, they still have a negative impact on the individual's life and overall well-being.

(c) Substance Use and Addictions (i.e. Opioids)

Substance use disorder (SUD) is defined as "a treatable mental disorders that affects a person's brain and behaviour, leading to their inability to control their use of substances such as legal or illegal drugs (i.e. opioids), alcohol, or medications (NIMH, n.d.)." SUD is

treated generally done through evidence-based interventions such as therapy, counselling, medication, and peer/support groups. Treatments are highly individualized and as a result vary based on the individual's unique needs and depending on the stage they are in their recovery.

2. Types of Mental Health Treatment

There is no single form of treatment for common mental health disorders, such as anxiety and depression, which can ease the disorders in every case (Harvard Medical School, 2020). However, the two most known forms of mental health treatment for depression and anxiety are medication and therapy. Commonly prescribed medications include anti-depressants, such as selective serotonin reuptake inhibitors (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs), which are used to treat depression as well as other conditions such as anxiety, pain, and insomnia; and anti-anxiety medications (i.e. benzodiazepines) which help reduce symptoms of panic attacks.

In terms of therapy treatments, psychotherapy is defined as a "talking-based" form of psychological treatment which is used to treat mild to moderate forms of mental illnesses, such as anxiety and depression (CMHA, 2018). There are many different models or types of psychotherapy, including: cognitive-behavioural therapy (CBT), interpersonal therapy (IPT), psychodynamic therapy, dialectical behavioural therapy (DBT), and solution-focused therapy (CAMH, n.d.-d). Research suggests that psychotherapy is one of the most effective forms of treating common forms of mental health disorders such as anxiety and depression when compared to use of medications alone (CAMH, n.d.-b; Gratzer & Goldbloom, 2016). This is particularly the case for individuals who are dealing with mild to moderate forms of anxiety and depression, as they are likely to respond extremely well solely to psychotherapy as a treatment alone (Harvard Medical School, 2020). However, that is not to dismiss that existing research has shown that in many circumstances, both medication and psychotherapy should be used together to effectively treat anxiety and depression, particularly for more severe cases. Earlier research has suggested that the reason for this is that psychotherapy and medication potentially have different effects on the brain (Havard Medical School, 2020).

CBT is a form of psychotherapy that is structured, time-limited, problem-focused and goal oriented and that focuses on connecting thoughts to behaviour and emotions. It aims to help people learn to identify, question, and change how their thoughts, attitudes and beliefs relate to the emotional and behavioural actions that cause them difficulties (CAMH, n.d.-a). It involves the collaboration and conversation between a professional such as a psychologist, psychiatrist, counsellor and a patient or client.

There are differences in the levels of intensity of CBT treatments which are dependent on the level of contact with the therapist. Most clients will start off with "low intensity" which consists of telephone coaching, working with workbooks and other tools to help cope with issues.[2] "High intensity" consists of the more traditional form of therapy in which clients work in a one-on-one relationship with a therapist, usually in person, to address psychological concerns through talking.

Despite the differences in level of intensity and contact, low-intensity CBT is based on the same principles of high-intensity CBT in the sense that clients are required to reflect on and strive to change their habits of thought that could be contributing to their mental distress, and they learn coping strategies and other skills. However, low-intensity is offered in a way where there is a reduced need to extend one on one time with a qualified psychotherapist (Jarrett, 2017). Instead, it is reliant on workbooks and internet exercises, which are completed under the guidance of a "well-being practitioner" who may not have received formal training in psychotherapy, but has been trained to follow a highly structured program. In contrast, a high-intensity intervention would take place with a formally trained mental health professional (i.e. psychologist). Regardless of the level of intensity or the mode of services delivery, evidence-based research shows that CBT is the most effective form of psychological treatment in terms of successfully treating common mental health mental health disorders such as anxiety and depression (CMHA, 2018).

While both British Columbia and Ontario opted for CBT-based programs, it is important to highlight that this was a choice. CBT is not the only form of psychotherapy treatment that can be used to address mental health concerns, including treatment for anxiety and depression

[2] Bounce Back is a low intensity form of CBT treatment which is available in both Ontario and British Columbia.

related disorders. In terms of the other types of psychotherapy treatment options, IPT is a form of psychotherapy that focuses on relieving symptoms by improving interpersonal functioning. The central idea around IPT is that psychological symptoms can be understood as a response to current difficulties in everyday relationships with other people (CAMH, n.d.-c). Psychodynamic therapy originates from the work of Sigmund Freud and is a form of psychotherapy that explores the connection between the individual's past experiences – often from childhood – to present day. The goal of psychodynamic therapy is for the individual to develop self-awareness and understanding of how their past influences their present behaviour. DBT is a form of psychotherapy that helps individuals learn and use new skills and strategies so that they build lives they feel are worth living. It focuses on helping people accept the reality of their lives and their behaviours, as well as helps them to learn to change unproductive behaviours to their lives. Finally, solution-focused therapy is a short-term and goal-focused approach that incorporates positive psychology principles and practices which encourage individuals to change by constructing solutions rather than focusing on problems.

Psychotherapy, in all its different forms, can be delivered in a range of different formats of therapy, such as individual, family, couple, and/or group-based sessions. Despite the strong and existing evidence of the effectiveness of the various different types of psychotherapy in alleviating, at least in part, mental illness, the mental health treatment needs of citizens in accessing psychotherapy are currently not being adequately addressed through Canada's publicly-funded healthcare system (Vasiliadis et al., 2021). In that context, both Ontario and BC opted for a similar treatment approach, albeit at different levels of intensity for CBT-based programs.

3. Mental Health Providers

When seeking mental health support, it can be challenging for the average person to navigate the system as there are a range of professionals who are able to offer some aspect of talk-based forms of therapy, including psychiatrists, family or generally practice physicians, nurse practitioners, psychologists, social workers, clinical counsellors and others (CAMH, n.d.). The overlapping scopes of practice between these different healthcare-based professionals have generated tensions between the various providers and their professional associations and

created confusion surrounding appropriateness of treatment service provision. These difficulties are further complicated by the issue as to whether the various professionals are appropriately licensed/unlicensed and regulated/unregulated by or through a respective self-regulating college or body and whether their services are paid for by governments as medically necessary services. While the provision of collaborative-based healthcare is likely to produce the best patient outcomes, research has shown that “deep rooted prejudices and professional territoriality” within healthcare, including mental health certainly exist (Chung et al., 2012). The tensions are further exacerbated when some providers are covered through public health insurance or are otherwise publicly funded, whereas others are not, as shown in **Table 1** (Mulvale et al., 2007).

Family doctors/general practitioners and psychiatrists, who are both medical physicians, are one type of mental health service provider and would consist of the highest level of medical or psychological training or education. These treatment providers are associated with a medical model of care provision and must hold a three/four-year (depending on the Canadian medical school) medical degree in addition to at least a three-year Bachelors (in Canada). Both are medical doctors who can diagnose, treat and prescribe medications, and whose psychotherapeutic services are covered by provincial public insurance and would be considered “medically necessary” services. As a more specialized medical expert, in ordered to have access to a psychiatrist, a patient must be referred by a family doctor.

A second type of mental health professional are psychologists. This category of mental health service provider is marked by a high level of education, albeit not within the context of a medical degree. Generally, they have at least nine years of university education and/or may hold a PhD or PsyD in Canada. In terms of treatment services, they unable to prescribe medication and their services are also not usually covered by public insurance as being “medically necessary” services, unless delivered within an approved setting such as hospitals. Despite this lower level of “medical expertise” certain private health insurances may cover all or some of psychological services.

Psychotherapists are a different and third type of psychological service provider, and their services are also generally not covered by public insurance as being “medically necessary”.

In terms of training and education, they are expected to hold a Master's degree in counselling or some related field and are certified with the Canadian Counselling and Psychotherapy Association by meeting the CCPA's certification criteria.

A fourth category of health-related professionals that qualify as mental health counsellors vary widely in terms of their job title, pay and education: social workers (who may have a Bachelors or Master of Social Work degree, nurses (four-year nursing degree) and occupational therapists (Master's degree and accredited through the Canadian Association of Occupational Therapists).

Outside of general practitioners and psychiatrists, all of the other listed mental health providers charge patients for psychological services, either out-of-pocket or through private insurance, unless they (psychologists and social workers, namely) are working in government-funded hospitals, clinics or agencies or through private employee assistance programs (CAMH, n.d.; MHCC, 2017).

Table 1

Covered by Public Insurance as medically necessary	Not Covered by Public Insurance
General Practitioners/Family Physicians (MD)	Psychologist (PhD, MA)*
Psychiatrists (MD)	Psychotherapist (Msc)*
Nurse Practitioners (NP)	Social Worker (BSW, MSW)*
	Occupational Therapist (Msc(OT))*
	Other non-medical professionals*

* These mental healthcare providers may be free at the point of use if they work in government-funded hospitals, clinics or agencies or an employee assistance program (CAMH, n.d.)
*If you are a student, counselling services may be provided for free by your high school, college or university. Some communities may have free clinics, support groups and drop-in centers that provide counselling (CAMH, n.d.)

Canada's Mental Healthcare System

In Canada, mental health care is currently provided through a two-tier system. As mentioned previously, the Canada Health Act sets conditions for provincial governments to receive federal funds for health, and one key requirement is that provinces provide public coverage for health services that are deemed "medically necessary." The scope and coverage of

what is deemed “medically necessary” has been subject to controversy as there are many healthcare services that are either unfunded or only partially funded, including mental health.

Public funding for mental healthcare services such as psychotherapy has historically been limited to services provided in hospitals or by medical doctors – either family physicians or psychiatrists – and are covered by provincial plans as “medically necessary” services (MHCC, 2017). The downfall to heavily relying on the delivery of psychotherapy by those within the medical profession and as “medically necessary” provided treatments and services are the long wait times for publicly funded services as well as the lack of availability and accessibility for individuals, particularly those in rural communities (Murray & Knudson, 2023). Compounding and further exacerbating this problem is that many Canadians are struggling to find a family physician. Young Canadians have especially reported waiting up to a year for any kind of mental health treatment, and one-third of those same Canadians reported that they did not receive adequate assistance, if they received any at all (CMHA, 2017). Furthermore, fifty-five percent of family doctors ranked access to psychiatrists from fair to poor (CMHA, 2017).

In 2001, approximately 80% of mental health consultations with psychologists took place within the privately funded system. It has been estimated that Canadians spend $950 million annually on private psychologists’ services alone. Nearly 30 percent of this expenditure is funded out-of-pocket, with the remainder primarily coming from employment-based private health insurance plans (MHCC, 2017). Even though approximately 60 percent of Canadians have some form of private employment-based insurance, the amount available for psychotherapy may only cover a handful of sessions (The Globe and Mail, 2015). Typically, private insurance covers an annual maximum of between $500-1000, although it does vary depending on the sponsor (MHCC, 2017). Those with access to higher levels of benefits are likely to be those in higher-income jobs and with stable employment. This means that the 1 in 5 Canadians who are classified as “low income,” and who are much more likely to report having poor to fair levels of mental health, have less access to counselling, psychotherapy and psychological services (MHCC, 2017).

Canadian studies of mental health policy often take the UK’s nation-wide policy reforms in the early 2000s as potential models of reform. Both Canada and the UK have similar general

practitioner (GP) gatekeeper systems (Vasiliadis et al., 2021). The UK sought to expand the delivery of psychological services through the Talking Therapies program (previously known as Increasing Access to Psychological Therapies or IAPT) which focused on increasing access to high and low intensity CBT throughout the country. However, given its limited role in the delivery of healthcare and mental healthcare treatment and services, Canada's interventions at the federal level have centered around knowledge exchange and advocacy, primarily done through the MHCC and have left mental healthcare reform almost entirely in the hands of provincial governments (CAMH, n.d.).

Research Questions

There continues to be no universal access to broad based and fully comprehensive publicly funded psychotherapy in Canada and no government has gone so far as to designate or deem psychotherapy as a "medically necessary" treatment or service under its provincial insurance plan outside of traditional physician or hospital care. In response to the evolving mental health crisis, two Canadian provinces, British Columbia and Ontario, took the initiative to expand access to various types of publicly funded psychotherapy within their respective jurisdictions. BC adopted a smaller policy change through the adoption of a relatively modest program, Bounce Back, starting in 2008 while Ontario pursued a larger policy change with a more ambitious pilot program, the Ontario Structured Psychotherapy Program, in 2017.[3] This dissertation focuses on these initiatives in BC and Ontario to expand publicly-funded psychotherapy, and asks why the provinces varied in the timing and the scope of their reforms?

My research explores these questions of both the timing and scope of policy change through consideration of four theoretical approaches that provide different (and potentially overlapping) understandings of the factors associated with policy change and stability more

[3] Despite Ontario and British Columbia being my selected case studies, they are not the only provinces to have made attempts at adopting a province-wide publicly funded psychotherapy program. On December 3, 2017, Quebec announced that they would be making a recurring $35M investment into the province's first ever publicly-funded psychotherapy program. Quebec's Health Minister Gaètan Barrette stated that the province's mental health sector was "insufficiently developed (CBC, 2017)." The new program would cover the services of psychologists of people requiring mental health support such as depression and anxiety. Similar to the UK's nation-wide publicly funded psychotherapy program, the *Talking Therapies* (formerly known as Increasing Access to Psychological Therapies (IAPT)) programme, the program is committed to providing the necessary resources to provide adequate services to three percent of the population – the percentage of those in need of assistance, which amounts to approximately 240 000 Quebecers.

generally. First, it will examine the ideational context and role that ideas play in contributing to policy change or stability, particularly given the changing priorities of mental illness and corresponding effects on treatments and treatment providers leading up to and following the Kirby report. Second, it will also examine the role of policy legacies as potential barriers to change, particularly in light of the dominance of the medical model of treatment in the broader health care policy space and the mental health space in particular. Third, it considers the roles that individual and organizational actors can play as policy entrepreneurs that may lead to different based policy outcomes, depending on their efforts and focus. Fourth, and finally, it will also consider the role of policy learning and transfer, since these two important provincial innovators (BC and Ontario) chose programs that are similar to or based on the UK's widely studied and praised Talking Therapies program, but they did so at different times and to different extents.

The existing literature on mental health care in Canada *describes* the problems surrounding the lack of access to psychotherapy, as well as recommendations towards Canada adopting similar programs as the UK (Bartram, 2019; MHCC, 2018). However, there is a lacuna in the literature with regards to *explaining* the pattern of psychotherapy program adoption and reform in the Canadian provinces, specifically, in Ontario and British Columbia, which have both been innovators, albeit in different ways. Furthermore, the four theoretical approaches to policy change in isolation from one another do not explain this variation in outcomes on timing and scope of policy change. Rather, it is a combination of the four theoretical approaches which allow for a more fulsome explanation of policy change in my case studies.

In BC, accessing high-intensity CBT (which is offered through both the public and private sector) is difficult, particularly within the public sector where it is only available as a publicly funded service through hospitals or physicians (Lau, 2009). This is due to a mixture of a lack of accessibility and too few mental health providers who have been properly trained to deliver high-intensity CBT. Similar problems existed in Ontario. Given the similar institutional constraints and facing the same mental health care problems and at the same time, there is a lack of explanation as to why the two provinces made the different decisions that they did, in terms of the level of intensity of psychotherapy programs they chose to adopt. In addition,

there is a variation in the timing of adoption of programs to address the mental health crisis, despite sharing similarities in terms of having a lack of access to psychotherapeutic services through public coverage - OHIP for Ontario and MSP for BC and being limited to only through primary care, mental health clinics, and health teams. Yet, Ontario has chosen a centralized, standardized, top-down policy initiative in term of delivery of psychotherapy services for their citizens, albeit almost a decade later, whereas BC has not chosen to go down that route thus far, but did intervene to address the mental health crisis much earlier.

The UK case provides an interesting comparison to Canadian reforms. The UK's Talking Therapies program, which combines high and low intensity CBT programs, was fully adopted in 2008, and is often studied as an international leader in expanding public access to psychotherapy. Broadly speaking, this national program uses a stepped-care approach, which is a framework that aims to provide the most effective, yet least resources needed level of intensive mental health treatment for the individual seeking mental healthcare support (Centre for Innovation in Campus Mental Health, n.d.). Within this approach, you step up to more intensive/specialist services if it is considered necessary from a clinical perspective or in other words, more intensive treatment is necessary (Centre for Innovation in Campus Mental Health, n.d.). BC adopted the virtual, low-intensity CBT Bounce Back in 2008, simultaneously when the UK launched their Talking Therapies program. In contrast, Ontario's Structured Psychotherapy (OSP) Program was officially launched in 2020, more than a decade later and is a smaller replica of the more comprehensive $600 million-a-year UK's program (Layard, 2015). It offers both low and high-intensity CBT.

While policy variation is expected in a decentralized country or federal state, such as Canada when compared to the UK which has a unitary government, there is a still a gap in terms of explaining why BC and the UK launched a program in the same year, and Ontario followed suit about a decade later. Because Canada is a federation where provinces have jurisdiction over health services, we do expect the possibility that Ontario and British Columbia could make different decisions to address their mental health crisis. However, there is a lack of literature explaining why these reforms occurred at the time they did, as well as why British Columbia has

not expanded their publicly funded mental services since then, or why they apparently have not been further influenced by the UK's Talking Therapies program.

The main purpose of this thesis and its contribution to political science and mental health policy will thus be to examine the applicability of four political science theoretical frameworks to understand why two Canadian provinces, Ontario and British Columbia, who faced similar (if not identical) mental health crises, had different mental health policy reforms and outputs. In terms of potential explanations, learning from abroad poses some potential. The UK and Australia are often praised by mental healthcare leaders as international leaders that Canada should look to for expanding access to publicly funded psychotherapy. The existing literature shows that in the case of the UK, they adopted a nationwide program to address mental health needs because it was economically sustainable and produced jobs at a time when the country desperately needed it. The impetus for the program came from policy entrepreneurs outside government but found strong support in the Labour government of the day (Bartram, 2017; D. M. Clark, 2018). While there is a reasonable explanation for these countries, there is a visible gap in the literature for Canadian provinces, namely, Ontario and British Columbia, who were facing a similar mental health crisis, had access to the same information about the cost-effectiveness of CBT, yet, made different decisions in terms of *when* they decided to adopt their programs, and the *comprehensiveness* of the program. Certainly, it is expected that Canada would not act on a nationwide basis given that health policy primarily falls under the jurisdiction of the respective provincial and territorial governments. Thus, the puzzle for this dissertation is why Ontario decided to adopt a more fulsome publicly-funded-psychotherapy program in 2017, and why BC did so *earlier*, but has not expanded their mental health services since that time.

This empirical question reflects an ongoing and much more broad-based debate in the academic literature on public policy – what explains the timing and intensity or scope of policy change in a given policy space or with respect to a particular and specific public policy or program versus when policy stability blunts or constrains efforts at reform. To reiterate, I argue that the changing ideas on the understanding of mental health (i.e. severe mental health concerns to mild to moderate illnesses), as well as the appropriate types of mental health

treatment (i.e. institutionalization to community-based treatments) and the expansion of treatment providers led, at least in part, to policy change in both provinces, albeit at different times and different levels of intensity/scopes of treatment. In the case of Ontario, where the later and larger policy change occurred, it was also through the role of policy entrepreneurs who had influence and strong ties in and out of government, who played a key role in the adoption of a province-wide higher intensity program. In the case of BC, while there was an initial small scale policy change supported by policy actors outside of government, we observe an absence of (as well as a lack of success) those same or different policy entrepreneurs in the province, which led to the lack of a larger scale policy change in keeping with that of Ontario.

In pursuit of this inquiry, this dissertation is organized into five further chapters. Chapter two sets out the literature on policy change and highlights four main and potential theoretical explanations for understanding policy change more broadly and the different policy approaches in BC and Ontario more specifically: ideas, policy legacies, the role of policy actors and policy learning. It argues that, given the competing or overlapping theoretical entanglements, a single theoretical explanatory variable is not sufficient in providing a fulsome explanation for variations in policy change in terms of timing and scope. For example, it demonstrates that ideas are an important concept that interact and are present in the other theoretical explanations but cannot exist on their own. As such, explaining policy outcomes involves and is dependent on a combination of different factors and, in particular, the roles played by or the absence of policy entrepreneurs and policy learning and in the context of institutional constraints and/or opportunities. Chapter three demonstrates, albeit briefly, that the academic debates that exist in policy studies and political science more generally on the factors and primary causes of policy change versus policy stability also exist in the health policy sphere. It then explains why the health policy sphere, and the mental health policy sphere in particular, is an ideal case study to explore the dynamics of policy change and stability before setting out the process tracing and case study approach and methodology and the manner in which the research of these two cases was pursued. Chapter four sets out the empirical findings with respect to mental health policy change in British Columbia (early and small). It highlights that while some initial policy learning from other jurisdictions did take place by policy actors outside

of government and in a newly configured ideational policy space, the continued shifting and contestation of ideas on mental illness priorities, treatments and treatment providers were insufficient in overcoming the institutional constraints surrounding the medical model, and due to lack of influential policy entrepreneurship from within and by key actors in government. Chapter five provides the empirical findings with respect to mental health policy change in Ontario (late and large). It details that against the background of broader shift in priorities of mental illness, strong and influential policy entrepreneurship played an important role in overcoming institutional constraints through the introduction and eventual adoption of new ideas in and for the province, and assisted through learning from other jurisdictions. Chapter six consolidates the empirical findings, pointing out the importance of the role of actors and policy learning in a changing ideational policy space as the main explanations for the scope and timing of policy change in BC and Ontario before considering how these two cases reflect and reflect on broader understandings of the policy change versus stability debate.

CHAPTER 2: LITERATURE REVIEW

Access to healthcare remains a perennial and near universal concern across many Western democracies, and Canada is no different. Canadians consistently rank healthcare as a highly important policy issue facing the country (Soroka, 2007). While a wave of discontentment towards the healthcare system has swept across Canada since the 1990s, particularly in relation to access to primary care, it was especially brought to light during the COVID-19 pandemic (Khalil-Khan & Khan, 2023; Soroka et al., 2013). Access to primary care, for both physical and mental health, is a key issue in health policy. As a subset of public policy, health policy encompasses a broad range of public policies, programs, strategies and activities in public health, healthcare, and intersecting social systems that impact people's well-being. It is also concerned with the individual and collective determinants of health that have also not only become increasingly understood but have also broadened the scope of health policy beyond the medical sciences disciplines and have incorporated a more fulsome and related range of health or quasi-health concerns (i.e. policy spaces that are not traditionally considered as falling solely within the healthcare field). In other words, the policy space is one that is made up of not just healthcare providers but rather incorporates a wide range of interests and actors – each with their own understandings of the policy challenges and the solutions necessary to address them.

As a result of these two aspects, high public salience and multiple interactive and complex policy problems and solutions, access to primary healthcare constitutes either a complex or "wicked problem" (Peters and Tarpey, 2019). First introduced in 1973 by Horst Rittel and Melvin Webber to describe emerging policy issues that did not correspond neatly to the conventional models of policy analysis (Peters, 2017), wicked problems share the following characteristics:

1. No definitive formulation;
2. Lack inherent logic that signals when they are solved;
3. Solutions are neither true or false, only good or bad;
4. No way to test the solution to a wicked problem
5. Cannot be studied through trial and error;
6. No end to the number of solutions or approaches;

7. Unique;
8. Always described as a symptom of other problems;
9. Its description determines its possible solutions.

There is a broad understanding that the delivery of healthcare, including access to primary care in many jurisdictions, and the inherent complexities and conflicts therein "serve as fertile grounds" for wicked problems (Periyakoil, 2007).

Similar to other wicked problems, healthcare involves many moving parts: a complex system of issues and stakeholders, care networks, financial concerns, clinical standards and protocols, public relations and government regulations, among other considerations. Furthermore, health policy and healthcare are both inherently political and fundamentally rooted in public policy as they address *who* gets what, *how* they get it, and *why* they get it (Greenhalgh & Russell, 2009; Lin & Gibson, 2003). This is demonstrated through an increasing focus on broader public policy concerns associated with the social determinants of health, which the World Health Organization defines as "non-medical factors that influence health outcomes (World Health Organization, n.d.)" such as income, housing, and education. With an increased number of these types of issues being newly or otherwise differently politicized and tossed into the health policy arena, and considered as such as public health issues, this has further complicated the role of healthcare providers, such as physicians, who have traditionally been portrayed as politically "neutral" and as nothing more than service providers. This notion of neutrality among and within the healthcare sector has undergone a major paradigm shift, as research shows that the beliefs of individual healthcare providers influence their choice of specialty or even affect their interactions with patients and treatment decisions and have played an increased role in policy advocacy. Thus, when health policy is, in fact, viewed as a part of a broader public policy agenda, it becomes clearer that decisions made in this field are inextricably linked with power and politics (Bambra et al., 2005; Oliver, 2006).

Public health researchers often criticize political scientists for being "too theoretical" in their approach (Gagnon et al., 2017). Political scientists, on the other hand, often consider public health researchers to have a "naïve" understanding of political reality, when in fact, the two fields heavily overlap (Gagnon et al., 2017). Additionally, while some public health

advocates might pose the argument that healthcare should not be political, in an interdependent world, very few initiatives have proven to emerge from a purely humanitarian objective (Kickbusch & Liu, 2022), especially in the field of mental health. However, despite this broadened understanding of the importance and scope of healthcare as a policy space, "the politics of health," or more recently, "the political determinants of health" still remains largely absent in mainstream debates surrounding access to healthcare (Bambra et al., 2005). This has especially been the case in mental health, which has traditionally been neglected, underfunded, and overlooked by policymakers and politicians alike to the extent it earned itself the nickname "the Orphan Child of Medicare" (Kirby & Keon, 2006).

This chapter pursues a more politics-focused approach to understanding policy change and stability and presents an overview of four well-established public policy theoretical frameworks that provide insight into the multiple actor and problem definition aspects of wicked problems. It explores explanations surrounding ideas, institutions, interests or actors and policy learning, to support my argument that while public policies maintain institutional stability for the most part, there are opportunities for policy change through 'windows of opportunity,' driven by and in the context of changing ideational understandings of policy problems, actions and activity from influential actors, and policy learning from within or abroad. This chapter sheds light on the competing nature of these theoretical arguments, particularly and ultimately when applied to understanding the mental health policy space and the corresponding changes that took place in BC and Ontario.

There has been an increasing emphasis on the role of ideas when considering explanatory variables on policy change and stability. While institutions certainly constrain and limit the impact of ideas in the policy process, ideas hold immense power in facilitating and promoting policy change as well. Furthermore, ideational processes can impact the way elites and other policy actors perceive their interests and the environment in which they mobilize (Béland, 2009). Elites and policy actors who are influential (i.e. politically or socially), wealthier, and well-organized hold the ability to be deliberate and strategic in packaging and framing policy ideas to convince their networks as well as the general public that certain policy proposals constitute plausible and acceptable solutions to pressing problems (Campbell, 1998).

Thus, I argue that ideas remain central to the politics of policy change and ultimately are necessary in helping to explain both the overall policy change in mental health policy in both jurisdictions and the different policy outcomes in BC and Ontario.

However, ideational theories and their explanations do not provide a sufficient explanation in of or by themselves to explain change or stability. I argue that the context of shifting ideas (and priorities associated therewith) of mental health illness and care, from the nature of the illness (serious, long-term illnesses to treating mild to moderate forms of anxiety and depression) to the appropriate types of treatment (institutionalization and prominence of the medical model to community-based treatment) and treatment providers, opened up space for other policy considerations, such as policy entrepreneurship and policy learning, to take root. When coupled with the actions of key policy entrepreneurs, these new understandings and priorities of mental illness, treatments and treatment providers were sufficient to overcome resistance in the broader psychiatric and psychological communities and include a wider range of actors in in mental health care delivery in Ontario, and due in part to external influences and learning from the United Kingdom as well as from within. In contrast, these same (or in the case of the nature of illness priority, still evolving and shifting) ideas and factors were insufficient in being able to overcome the more entrenched interests in BC due to the lack of key and successful policy entrepreneurs within government in either being able to maintain the priority on anxiety and depression as the focus of mental illness policy or by pushing for broader and more comprehensive programs and thereby limited the overall scope of policy change. The remainder of this chapter outlines the foundations of these theoretical arguments, and the corresponding criticisms associated with the same.

(a) **Role of Ideas**

The emergence of discursive institutionalism (DI) as the fourth school of institutionalism in political science has further increased the number of scholars who assert that 'ideas matter' in explaining policy change and outcomes (Béland, 2016; Campbell, 2002; Parsons, 2016; Schmidt, 2008). As Schmidt (2008) states, providing a single definition for ideas is difficult as "there are so many ideas about ideas" (Schmidt, 2008). In this regard, ideas have been defined as or

considered to be switches for interests, road maps or focal points; as strategic constructions or strategic weapons in the battle for control; as narratives that shape understandings of events or as "frames of reference"; and as collective memories or national traditions (Blyth, 2002; Etheredge & Short, 1983; Fukuyama & Katzenstein, 1997; Jabko, 2012; Jacobsen, 1995; Jobert, 2006; Roe, 1994; Rothstein, 2005). But the simple definition for ideas is that they are: "beliefs held by individuals or adopted by institutions that influence their actions and attitudes (Beland & Cox, 2010: 6)

Traditionally, ideas were viewed as 'soft' policy influences but since then, policy researchers have come to accept that ideas should be taken more seriously as a causal variable in explaining public policy outcomes (Cairney, 2019; Mehta, 2010). Ideas have increasingly become viewed as strong policy influences in their own right (Cairney, 2019; Mehta, 2010; Swinkels, 2020)2025-09-24 1:36:00 PM. As Hall (1993) states, ideas can structure the policy-making process, similar to how they are able to be structured by institutions. Ideas can also overcome institutional constraints, which are particularly helpful in traditionally neglected and complex policy areas such as mental health (Macnaughton et al., 2013; Mulvale et al., 2014; Spillane et al., 2002). By first changing people's beliefs and preferences, ideas hold the ability to play a key role in changing people's behaviours (Hand, 2012). Ideas help define policy problems which influence the content of reform proposal and act as "discursive weapons" in constructing the imperative for reform (Béland, 2009).

Since the mid-1970s, the social sciences community has debated over the meaning of ideas and the idea of power. Carstensen & Schmidt (2016) pose that discursive institutionalists have associated the notion that 'ideas matter' for policymaking with 'power through ideas.' However, they also argue that the existing literature has failed to elaborate on the full notion of ideational power. They state that there are three different types of ideational power:

(a) 'power through ideas,'
(b) 'power over ideas,' and
(c) 'power in ideas.'

In terms of 'power through ideas', they define it as "the capacity of actors (whether individual or collective) to influence other actors' normative and cognitive beliefs through the use of

ideational elements" (321). In other words, political action involves the ability of policy actors to persuade others to pursue a course of action through the force of ideas.

Power over ideas is focused on the ability of influential actors, who normally have institutional status and power, to control or dominate others by through their ability to determine which ideas are considered, listened to, resisted or rejected outright (Cartensen & Schmidt, 2016). According to Carstensen & Schmidt (2016), this generally takes forms in three ways:

(1) by actors with power to impose their ideas;

(2) by normally powerless actors who seeks to shame other actors as a tactic to get them to confirm to their ideas or norms; and

(3) by actors who have the capacity to resist even consideration alternative ideas.

In short, power over ideas involves the ability of key policy actors to decide which ideas are considered.

Finally, power in ideas takes place through the establishing of structural, hegemonic or institutional foundation that imposes what the range of ideas are and can be considered (Carstensen & Schmidt, 2016). It determines the receptiveness of the overall environment in which policy actors operate to different ideas.

The first two aspects of ideational power focus on the direct use of ideas as causative elements in the policy making process and are more immediate factors and more directly associated with policy impact. In contrast, the third aspect of ideational power is about the softer impact of ideas on the more distant background ideational processes, such as the systems of knowledge, discursive practices and institutional set-ups which in important ways influence which ideas enjoy authority at the expense of others and operate at a more distant level of policy impact. While both aspects of ideas can impact policy change, the softer side may have more of an enduring impact (and also help explain policy stability) by establishing a prevailing (and difficult to change) understanding of the policy problem and the corresponding range of potential solutions.

In this more constitutive or background sense, ideas ultimately shape and impact the way human beings think and make decisions. They can be portrayed as heuristics or subjective

beliefs which help people make sense of the complex world around them. This means that people depend on pre-existing ideas to help understand and guide them through situations (Jones, 2017). Whether ideas serve as concrete (or concretized) beliefs, cognitive short-cuts, mental aides, or heuristic devices which filter through the information that is viewed or judged, it is important to take a policy actors' beliefs on policy outcomes seriously (Brummer, 2016; Jacobs, 2009; Radaelli & O'Connor, 2009). Jacobs (2009) examines how there is a lack of a consideration of the cognitive mechanisms through which ideational frameworks shape political elites' preferences from other options. He argues that actors' mental models of the domains in which they are operating systematically guide their attention within processes of decision-making. Boothe (2011) also agrees that elites deal with an overwhelming amount of information about policy choices, and they mitigate this by using mental models that structure the type of information to which they need to pay attention and bias in the way they handle new or disconfirming information. In this sense, ideas and pre-existing understandings of a policy problem constitute and become key determinants of policy choices, outputs, and outcomes. Thus, this means that even the best and readily available evidence and/or treatment (i.e. the evidence-based psychotherapy) may be rejected because it does not fit into the existing way or "mental frame" (Prinja, 2010) of how the elite or decision-maker understand the policy issue at hand. Prinja (2010) also adds that certain information, due to biases, may be viewed as superior over others, i.e. medical or biological evidence vs. social sciences. This may also serve as a potential explanation as to why medical associations have historically had greater success in having their voices heard within public policy over non-medical sectors (Prinja, 2010).

Despite the organizational and resource imperatives of existing understandings in a policy space, dominant ideas in a policy sphere can become and often are contested, either strategically and/or instrumentally or as part of a broader or underlying changing cognitive belief structure. The outcomes of these ideational challenges can serve to:

(a) reinforce the existing understanding;

(b) slightly modify, expand or otherwise mildly or incrementally alter the existing policy space with limited impact on the underlying beliefs; or

(c) result in a wholescale redefinition of the meanings within the policy space. (Baumgartner and Jones, 1993)

Ideas do not exist or operate on their own - actors engage with them, reinforce them, adjust them, and/or challenge existing ones through differential framing and political discourse (Swinkels, 2020). In other words, ideas not only operate in the background, but can also be used strategically and intentionally to drive and support policy change. For example, when the policy agenda is filled with competing priorities and issues, the intentional portrayal of policy problems and solutions (that is to say, ideas and how they are framed) is crucial in gaining traction to bring about policy change, especially in situations of busy policymakers who have limited time, attention and resources. Thus, the role that actors play in their use and interaction with particular ideas and the impact of those ideas is an important consideration on the overall explanatory power of ideas more generally. Policy entrepreneurs guide actions through and use ideas as strategic tools to craft political discourse and as institutional frameworks that could potentially have an effect on their own as well as a corresponding effect on other individuals, groups, and society by maintaining order among (Blyth, 2001; Stone, 1989). In short, the way that actors use ideas may also be a causative factor in policy change.

The extent to which policy actors can exercise ideational power and employ ideas as persuasive devices is inherently linked to the content and strength of an actors' values, their knowledge and level of involvement in the policy process, and the degree of their real or perceived expertise (Hall, 1993; Surrel, 2000; Lavis et al., 2004). Ideas are employed throughout the policy cycle by different and sometimes competing policy entrepreneurs in an effort to shape the agenda-setting, policy formulation and policy implementation stages by determining which representation of the problems and potential solutions to address the problems (in other words, ideas) will be best heard and understood by policymakers (Hall, 1993; Sabatier & Weible, 2007; Surel, 2000). But the ability to employ ideas in a causative manner is not germane to any type of policy actor. Rather, the power over and through ideas is inherently linked to the expertise and/or qualifications of the policy actors asserting them. In this regard, the importance of positional or policy expertise and the possession of technical information and knowledge of those policy entrepreneurs has risen as policymaking has increasingly become

driven by expertise in some settings (Radaelli, 1999; Beland, 2010). The use of research evidence, particularly, in areas of health policy has achieved international normative status in the past couple decades (WHO, 2005). This directly ties into my own research as psychotherapy, specifically cognitive behavioural therapy, has a strong evidence base for treating common mental health disorders such as anxiety and depression and that arguments in favour or advocacy of it by those both outside and, more crucially, within the medical community might increase its overall acceptance.

In a similar fashion, as Beland (2009) also notes, ideas can also be used to impact policy change in three ways and which correspond to Kingdon's Multiple Streams Framework (MSF): problem, policy, and political streams. First, ideas participate in the construction of issues and problems that enter the political agenda. Kingdon (1995) argues that given the number of competing policies on the political agenda, political actors, journalists, and citizens cannot focus their attention of numerous issues all at the same time. Thus, ideas about the current pressing issues and priorities serve as guides for actors to narrow the policy agenda. In other words, ideas participate in the construction of social, economic, and environmental problems that the political actors may choose to address (Stone, 1997). Thus, ideas can become politically influential if they are, in part, used within powerful institutional forces and/or by well-placed political actors (Hansen and King, 2001). High profile actors, such as elected officials, political parties, and even interest groups and social movements, can serve as instrumental in the propagation of policy ideas (Beland, 2009). This is important to note that specific ideas are likely to be more influential and result in policy change if a powerful actor promote them (Beland, 2009). As Hacker (1996) and Kingdon (1995) have noted, many relevant policy ideas often go nowhere because there is no influential policy entrepreneur who is willing to promote them. However, that is not to say that there have been no cases where ideas have empowered traditionally weaker actors.

One of Hall's (1993) major contributions to literature on policy change are his descriptions of paradigmatic policy change involving these foundational beliefs and ideas. Change can occur at three different levels. Each level is associated with deeper levels of change: First-order change is characterized by keeping the same set of goals and policy instruments but

changing the settings of the instruments. Second-order change consists of changing the instruments, but not the goals. These two levels of change do not disturb the underlying ideas or beliefs that serve to structure the policy space. Third-order change is more radical as it shifts both the policy goals and the instruments that are used. It alters the constellation of actors and the discourse and is triggered by the *paradigm shift*. A paradigm shift, inspired by physicist and philosopher Thomas Kuhn's theory of scientific revolutions and 'scientific paradigms' is a fundamental shift in which old ideas and institutions are overthrown or replaced with new 'paradigms.' According to Baumgartner (2013), "when ideas are shared by an entire policy community, they are called a *paradigm."* Hall defines paradigms as a "framework of ideas and standards that specifies not only the goals of policy and kind of instruments that can be used to attain them, but also the very nature of the problem they are meant to be addressing" (Hall, 1993: 279). Paradigms articulate the goals and perceived interests of political actors with concrete instruments and proposals meant to address specific problems (Béland, 2010).

Ideas remain at the core of Hall's explanation of policy change in his conclusion that policy change is highly constrained because ideas that support the status quo remain extremely powerful. However, in the presence of a paradigmatic shift, policies can be transformed, creating a new equilibrium. Howlett and Ramesh (2002) state that 'substantial change' also known as the 'big bang' is likely to occur when there is a presence of both new ideas and new actors in the policymaking process. Otherwise, when new ideas and new actors are absent, one should anticipate only 'minor' or 'incremental change.' However, while ideas can also serve as 'cognitive locks' that help reproduce existing institutions and policies over time (Béland, 2007), there is still potential for policy change to occur, through rapid change or gradual processes of policy evolution or a refocusing of priorities. Schmidt (2010) discusses that ideas can also be particularly useful in helping overcome institutional constraints.

Accordingly, a big question ideational scholars consider are why some ideas become policies, programs, and philosophies which dominate political reality, whereas others do not. The concept of ideas as strategic tools places emphasis on the active role of actors to consciously work with ideas. Actors engage with ideas, adjust them, and challenge existing ideas using political discourse and often in very instrumental ways. This is important because while

the nature of the idea may be one that is of value, if it does not fall in the hands of someone influential, it may fail to gain traction.

Without strong ideational entrepreneurs, ideas may have difficulty gaining prominence in groups or networks because there are so many of them in competition. Through positional power (i.e. job title and position) and rhetorical skills (i.e. clarity, persuasion, storytelling etc.), entrepreneurs can create, represent, promote, and embed ideas and the corresponding policy change that follows. In particular, through the use of discursive practices, actors can build coalitions, shape political agendas, and navigate the political arena, and effectively induce policy change.

Ideas may also dominate and serve as important strategic tools in policy domains, such as mental health, which are dominated by professionals where they possess a shared understanding and expertise (Weiss, 1990). By professionals, we are referring to individuals who are the 'experts' or carriers of knowledge or agents of formal knowledge. In this case, Weiss (1990) explains that the domination of ideas is not due to professionals being uniquely skilled in their presentation of ideas, but rather, because of the nature of their work. Professional work requires discretion and informed judgement about the appropriate response to a wide array of issues. Since professional work cannot be routinized, there is an opportunity to try new solutions on a case-by-case basis without disrupting the fundamental presumption of professional work. This flexibility fosters a sense of commitment among professionals which may motivate them to continue to innovate. Networks also play an important role in the creation, dissemination, and reinforcement of ideas. Ideas are often exchanged and reinforced over networks, thus, the pattern and structure of ties among actors affect the rate and reach of information dissemination. Networks have the power to reinforce or shift paradigms and values (Sabatier & Weible, 2007). There is also an immediate feedback effect in that the entrance of new ideas may be highly disruptive to networks. Values, preferences, experiences, and knowledge determine actors' propensity to form ties; thus, the clustering of actors around certain ideas may thus influence the shape of the network.

Lessons from Ideas

While ideational scholars and I both recognize that *ideas matter*, it can be quite daunting to unpack how they matter, provided the large scope of the existing literature on ideas, as "ideas can come from anywhere (Kingdon, 1984: 72)." On this front, ideas tend to be treated as relatively singular or holistic considerations, with the potential for impact at varying levels (Hall, 1993). However, ideas may consist of a subset of considerations that interact and impact on one another, such as in the health policy treatment where ideas of priority of illness and corresponding treatments and treatment providers may all intersect and impact policy choices individually or collectively and may all warrant consideration for their constitutive and causal impacts. These subsets or layers of ideas within ideas suggest further examination of the overall role of ideas and how they are defined and identified more generally.

The existing literature on ideas is also puzzling in that there is reference to them serving as both structural-like 'cognitive locks (Beland, 2007)' which re-produce institutions over time, whereas they can also serve as agency-based explanations in overcoming policy stasis. This suggests there are struggles surrounding the structure-agency question about the importance of ideas that needs to be reconciled within the neo-institutionalist policy literature and further explored in a different policy setting such as mental health. More specifically, as Macnaughton et al. (2013) argues, new or competing ideas hold the ability to overcome these existing *institutional and ideational constraints* are particularly helpful in understanding policy changes in areas of healthcare which have been traditionally neglected such as mental health. Through the ability of policy actors to influence policymakers and healthcare leaders' preferences, ideas hold the ability to play a key role in defining (or redefining) policy problems such as mental health, which in turn, shifts how problems are perceived, and which in turn shapes the potential solutions and policy agendas that are considered to address it. In the case of mental health, how a problem is understood or framed or the corresponding priority it is assigned is important as it can determine whether it receives "buy-in" by *elites.* In the case of mental health, these individuals are likely to be physicians, healthcare leaders and/or governmental leaders. Particularly in the case of healthcare issues, such as mental health, physicians hold significant power in shaping health policies, thus, having their support in the adoption of a program or

policy is likely to be more influential as opposed to other interest groups, particularly in an overlooked area of healthcare such as mental health (Mulvale et al., 2007).

The current literature on ideas focuses greatly on policy actors, broadly. Yet, there is a lot less literature on the notion of ideas driven by policy entrepreneurs and their preferences as well as their positional and professional expertise, and which may be advantageous due to their strong ties and alliances with policymakers and their unions (i.e. physicians), whereas others such as non-physician providers (i.e. psychologists) may not have the same access to these privileges and resources (Mulvale et al., 2007).

(b) Institutions, Historical Institutions, and Path Dependence

Douglass North defined institutions as "humanly devised constraints that structure political, economic, and social interactions. They consist of both informal constraints (sanctions, taboos, customs, traditions, and codes of conduct) and formal constraints (constitutions, laws, property rights) (North, 1991)." Other scholars define institutions through a variation of "the formal and informal rules, norms, precedents, and organizational factors that structure political behaviour (March & Olsen, 1983)."

Historical institutionalism places a heavy focus on the impact of long-term institutional legacies on policy processes. It starts from the 'assumption that a historically constructed set of institutional constraints and opportunities affects the behaviour of political actors and interest groups in the policy process' (Beland, 2007). Pierson (1993) explains that historical institutional analysis is based on the following (596):

(a) Political processes can be best understood if they are studied over time;
(b) Investigation of the structural constraints (broadly defined) on individual actions, especially those emanating from government, as they serve as an important source of influence on political behaviour;
(c) And, that detailed investigation of carefully chosen, comparatively informed case studies is a powerful tool for uncovering the sources of political change.

One of the strengths of historical institutionalism as a theoretical argument is that it has been used to explain both policy and political stability and policy change.

In terms of policy stability, historical institutionalism assumes that policymaking subsystems tend to be conservative and find ways of defending existing patterns of policy as well as the

organizations that make and deliver these policies (Peters et al., 2005). Pierson (2000) explains that there are self-reinforcing processes in institutions that make institutional configurations, thus, the policies make it difficult to change the pattern that has been established. Thus, there is an inherent tendency among historical institutionalists to assume that there is more of a logical trajectory or "retrospective rationality" than what may be the case.

Past policies can create a situation of path dependence that limits the available choices for policymakers to make future policy decisions. Pierson (2000) outlines path dependence as based on the following assumptions: "specific patterns of timing and sequence matter; starting from similar conditions, a wide range of social outcomes may be possible; large consequences may result from relatively "small" or contingent events; particular courses of action, once introduced, can be virtually impossible to reverse; and consequently, political development is often punctuated by critical moments or junctures that shape the basic contours of social life (251)." This type of policy 'lock-in' is a result of policy legacies that generate institutional procedures that force decision-making in a particular direction by either eliminating or distorting the range of policy options available (Pierson, 2000, 2004a). This concept can be applied to current existing institutions such as the delivery of healthcare in which past decisions shape and constrain future decisions. Despite new and emerging evidence of innovative solutions, policymakers may be reluctant to make policy changes due to high associated costs and resources or by prior commitments to the medical model (Mulvale et al., 2007).

Policy feedback also helps to explain policy stability to some extent and refers to the ways in which existing policies can shape key aspects of politics and policymaking (Béland & Schlager, 2019). Originating from historical institutionalism, the study of policy feedback has expanded to address resource and interpretative effects on target populations and mass publics, the role of policy elites, and how feedback effects are conditioned by policy designs and larger institutional contexts (Béland & Schlager, 2019). Pierson's (1993) analytical framework poses that there are two categories of effects that prior policies capture: resource/incentive and interpretative effects. He suggests that these effects affect three groups of key policy actors: government elites, interest groups and the mass public. Both factors are important to consider as these effects are self-enforcing and become policy legacies that will affect future policymaking. For

example, decisions to regulate healthcare service provision through professional associations may create both resource and interpretative effects that serve to “gatekeep” access to the profession or the range of services viewed as legitimate to provide and/or receive (Homrich, 2018).

Interpretative effects impact the way policies shape the worldview of political actors and their responses to policy development. Government elites and interest groups often respond to emerging policy issues with solutions that were successful in the past and the potential for new ideas or understandings of problems and solutions remains limited (Pierson, 1993). This is because new and untried policy solutions could potentially result in high risks and costs. The mass public may consistently vote for a particular party that adopts and/or implements policies which align with their personal world views and ideologies (Pierson 1993). Pierson (1993) articulates that feedback effects are likely to be the “most consequential in issue-areas” (or in countries) where interest group activities have not yet been established and there is a corresponding lack of challenge to the ideas or understandings of the existing policy frames. This is reflected in and connects with the role of ideas discussed above, and power-in ideas, with a greater focus on the ideational constraints as feedback institutions that subconsciously (or even unconsciously) structure the choices available to a wide range of actors.

Historical institutionalism has also sought to explain policy change through the punctuated equilibrium theory, developed by Baumgartner and Jones (1995), which serves as useful tool in understanding how policy change inherently occurs gradually, except in moments of significant disequilibrium. In particular, it explains why public policies tend to be characterized by long periods of stability and then punctuated by short periods of rapid and often radical change. It can also help public health actors understand why governments can sometimes be receptive to evidence and discussion leading to significant policy change, whereas at other times they may be less so and only open to making minor adjustments. Punctuated equilibrium has been used to study both changes in political agendas as well as in relation to specific policies and programs. In both cases though, there is an emphasis on dramatic shifts and less attention on subtle “drift” from existing policies.

A particular strength of punctuated equilibrium theory in analyzing policy dynamics is that it permits the inclusion of ideas and policy frames and relates the substantive element of policy images (as representations of those ideas and frames) to the strategic choices of policy actors and in the context of the broader institutional structures. Policy venues are "institutional sites where the portrayal of problems and solutions (ie. ideas) take place "(Baumgartner & Jones, 1993). They are locations where policies originate, obtain support, and are adopted as binding decisions. Actors may seek new venues when they need to adapt to institutional constraints in a changing environment – thus, they resort to framing processes or policy images and thereby the assertion of new or different ideas. Types of policy venues are formal political arenas such as legislatures, executives and the judiciary but also the media and stock market which can be venues for shaping and reshaping images of policy problems and the range of appropriate and available solutions. In the case of mental health, a traditionally undermined and overlooked field, existing institutional constraints may potentially benefit or be overcome rather through a different environment or venue or through the assertion of new ideas that correspond to the existing policy space and environment. Through the advancement of these new frames or policy images or ideas, policy actors may be able to overcome the institutionalized constraints of existing understandings of policy problems and solutions, particularly those presented by strongly entrenched and limited flexibility professional regulatory bodies seeking to protect the scope of their jurisdictions and practices, whether through the persuasive power of the images themselves or by shifting into more receptive and open policy spaces.

At a broader level, many scholars have identified the possibility of path-deviant institutional change having an impact on policies and programs through two streams: exogenous explanations on institutional change and endogenous developments. Exogenous explanations of institutional change usually consider change as a 'sudden collapse of institutional equilibriums, stability or patterns, usually caused by externally driven dramatic events such as wars, economic crises, dramatic technological developments, epidemics or natural disasters' (Sarigil, 2009: 123). In this context, the timing of policy change is fast and the scope is usually large. Endogenous processes of gradual change alter institutions in subtle but significant ways, through self-reflexive actors that 'gradually adjust their institutions in ways that are constrained by already-

given institutional practices, rules, routines, and cognitive schema' (Campbell, 2004: 34). Policy change from this perspective is usually slow and small. From either source of policy change, new understandings and new ideas of the policy space open up a range of possible alternatives to the existing policy directions and choices.

According to Mahoney and Thelen (2010) the type of institutional change that occurs is not dependent on timing but rather is related to the administrative and political characteristics of a country. They offer a series of hypotheses on the relationship between the characteristics of the political context, the institutions that are subject to change, the change agents and the modes of institutional change. They state that there are two broad questions that might characterize the political context in which institutional change takes place. The first question deals with the extent to which the political context affords defenders of the status quo strong or weak veto possibilities. In this regard, the shifts in the main concerns in a policy space, such as changes in mental health illness priorities, may provide such a context. The second question is concerned with the degree to which the targeted institution affords actors opportunities for exercising discretion in interpretation or enforcement (Mahoney and Thelen, 2010: 18, 20–21). A more open professional regulatory space provides greater opportunities than ones firmly entrenched on professional jurisdictional lines.

Boothe (2011) considers the impact of policy change from both pace and scope perspectives in the context of institutional effects. Large changes occur early in the policy development process and would normally be associated with rapid policy processes and provide the basis for subsequent policy feedbacks and policy legacies. In contrast policy options not considered at the initial stages tend to occur much more slowly, if at all, and are usually incremental or small in nature and have difficulty in overcoming the institutionalized logics of the initial policy development. Tuohy (2018) both expands on this dynamic of pace versus scope of policy change and contests the predominant explanations by setting out a four-fold typology of change that is dependent, at least in part, on institutional configurations of power. The types of change that can occur are (Tuohy, 2018):

1) big-bang (large scale, fast pace),
2) blueprint (large scale, slow pace),

3) mosaic (multiple small scale, fast pace), and
4) incremental (small scale, slow pace).

The type of change pursued is dependent on the broader institutional dynamics associated with degrees of centralized control and stability (ie. legacies) in the existing policy and politics circumstances. Tuohy however does provide the potential for policy change to occur at different times and scopes and in spite of the institutional constraints imposed by existing policy paths.

Lessons from Institutions, Historical Institutions and Path Dependence

The most common criticism of the historical institutionalism literature is that, despite its potential explanatory for both aspects, it tends to emphasize path dependence and historical legacies which explain stability rather than policy change (Hay, 2002: 15). Similarly, Thelen (1999) argues that path dependency is too sensitive towards initial conditions and too deterministic and mechanical with respect to subsequent policy development. A possible counterargument towards this criticism is based on the interpretation of stability in path dependency. Specifically, the notion does allow for policy change as policy legacies constrain rather than determine current and future policy. In other words, policy can change but within specific parameters, thus, posing the argument that policy exhibits stability (Kay, 2012). On this front, understanding the different types and, more importantly, scopes of change become more pressing (Pilon, 2021). In addition, there is a less clear and therefore greater need for consideration of the conditions and interrelationship between scope and timing of change.

(c) Policy Learning

Policy learning can be broadly defined as developing or updating knowledge and beliefs about public policy based on experience, interactions, analysis or rules (Bennett & Howlett, 1992; Dolowitz & Marsh, 2000; Dunlop & Radaelli, 2013, 2018; Freeman, 2008; Giuliani, 1997; Marmor et al., 2005; May, 1992). Rose (1991) states that policy learning occurs “when confronted with common problems, policymakers in cities, regional governments, and nations can learn from how their counterparts elsewhere on how to respond.” Rose’s conception of policy learning is aligned with Dolowitz & Marsh (1996)’s concept of “learning from abroad.”

Policy learning can be further defined and understood if it is separated into potentially occurring at three different levels: micro, meso, and macro (Moyson et al., 2017). Micro-level learning, which is the level of learning I am most interested in, occurs within and among individuals within social settings and is also known as 'social learning.' Examples of social learning are seen in Haas (1992) epistemic communities, Hall's (1993) social learning, and Sabatier and Jenkin's (1993) advocacy coalition framework. Meso-learning approaches focus on organizational learning which consider the role of learning from a business perspective on government action (Etheredge & Short, 1983; Metcalfe, 1993). Organizations learn in a way it affects their ability to identify, react, and adapt to the change in their environment. Meso-learning is useful as it allows for the detection and correction of errors, which in turn allow organizations to implement their objectives and norms (single-loop learning) and to modify these norms and objectives (double-loop learning) (Argyris & Schön, 1996). Lastly, macro-level learning which occurs at the system level, which occurs across government units.

This leads to questions of the importance of policy actors in the policy learning process by asking: Who learns? What do they learn? How do they learn? What is the effect of this learning? The initial question focuses on the actors who learn and their attributes. They can be individuals, groups (like advocacy or epistemic communities), or on a larger scale, political systems. In terms of what is learned, there are differences depending on the level of learning that is being discussed. At the meso-level, managerialist will utilize learning approaches that place greater emphasis on organizational learning via decisions and activities. Micro-level approaches might focus learning on individual values, norms, and policy preferences. Lastly, in terms of how the actors learn, the policy learning literature is interested in 'knowledge utilization' or ways actors take the existing resources of knowledge, information, and experience. Among the three types of learning, I am most interested in micro-level learning that may lead to widespread policy change.

The existing policy literature differentiates between different forms of knowledge utilization: instrumental and symbolic. Instrumental forms of knowledge utilization use knowledge as a key source for policymaking, whereas symbolic forms use knowledge as a source of legitimation for specific policy actors or policy objectives and helps establish the acceptability of various policy

choices (Moyson et al., 2017). Similarly, May (1992) also conceptualizes two different types of policy learning: instrumental versus social. Instrumental policy learning entails lessons about the viability of policy instruments or implementation designs and is inherently focused on more causative aspects of policy change and/or stability. Social policy learning is more constitutive in focus and entails lessons about the social construction of policy problems, the scope of policy, or policy goals. May (1992) claims that these two types of policy learning are not mutually exclusive of one another and that a policy change can entail either or both.

Dunlop & Radaelli (2013) argue that there are important differences in how knowledge is utilized based on the degree of control that policy actors have on policy objectives/ends and on learning content/means. In the case that the objectives/end are predefined, learning actors aim to find the best way to achieve those objectives. In the case where there are no specific objectives, policy preferences are endogenous to learning and can change through the cognitive and social process. When policy actors have control in the learning process, they rely on formalized or more sophisticated approaches and methods to learning such as science and experiments. For those who have less or no control, the process is less Bayesian and much more subject to informal social actors and disruptions.

Learning can manifest in different ways and in different degrees or scopes of learning, including knowledge transfer through interactions such as *copying* and/or *emulation*. Copying refers to the adoption of a policy or program without any alteration, which also alludes to the differing levels of scope of change a jurisdiction may decide to adopt. According to Sabatier (1987), this form of learning is rare, as it likely to only occur in the case where factors such as cultural, political, and social conditions are virtually identical across the said jurisdictions. Emulation, on the other hand, involves "borrowing ideas and adapting policy approaches, tools or structures to local conditions (Stone, 2001)."

Policy learning is also complicated and can be difficult to discern by virtue of the fact that it occurs during the policy process, which consists of politically engaged individuals, known as policy actors, who attempt to influence government decisions (Moyson et al., 2017). Policy actors can be from various affiliations whether it be politicians, public officials, managers of private or public organizations, pressure groups, academics and researchers, or active citizens

(Moyson et al, 2017). As part of this, these various actors may adopt ideas or policy frames subconsciously and without considering where they came from or if they fit. Learning can also be entirely random, biased, or even absent altogether (Dussauge, 2012; Shipan & Volden, 2012; Wolman & Page, 2002). Finally, policy processes do not occur in a vacuum but within the institutional systems of a country or a subunit of a country, which might be found in federal forms of government (Moyson et al., 2017).

In other words, there is a high degree of ambiguity in the concept of policy learning, from a definitional aspect as well as in both the scope and timing of policy change. Furthermore, learning can actually occur without there being any resulting policy change or in circumstances where there is only smaller or incremental levels of change. There are two reasons for this: first, policy learning might be one of many factors that contribute to policy change. For example, May (1992) and Dolowitz & Marsh (2000) demonstrate that instead of a governmental unit learning from policy success or failures from other governmental units, the decision to (or not to) adopt a policy could also be shaped by the degree of coercion, activities of a charismatic policy entrepreneurs, or by a shift in a governing coalition. There has been recognition that an increase in governmental intelligence, for example, will not necessarily result in greater government effectiveness (Etheredge & Short, 1983). Additionally, individuals hold their own biases and as a result, the combination of an actor or elite with their own individual ideologies or interests who exercises their power can often override knowledge gained about the severity and causes of problems and benefits and risks associated with various policy alternatives under consideration (Metcalfe, 1993).

Second, policy learning is, as mentioned previously, challenging and complex in that it is difficult to achieve or measure. Knowledge acquisition on complex policy issues can be both difficult to gain and difficult to discern because if no problem is perceived, little research will be done, problems will be poorly defined and may or may not receive a second glance, and not be viewed as relevant (Bennett & Howlett, 1992). Also, policy actors are not perfectly rational because they hold psychological biases such as “certainty effect” (Leach et al., 2013) or there is a high likelihood that they will tend to privilege what they believe rather than accept information that might challenge those beliefs. Another consideration is that individual learning

does not necessarily lead to collective learning and change (Heikkila & Gerlak, 2013). If learning occurs among a small group of individuals (micro-level), then upscaling this knowledge across a collective system or organization will require massive efforts. It may be easier for individuals with a strong network structure, such as physicians, in which knowledge exchange can occur across various stakeholders and organizations and ideally grab the attention of individuals with decision-making power i.e. policymakers.

Lessons from Policy Learning

Considerations of policy learning demonstrate that policy actors often do not create new ideas or policies on their own but rather rely on the efforts of other jurisdictions to justify their policy choices. In addition, this type of policy development can potentially help explain the scope of policy change through reliance on what has been done in other places but does little to help clarify when policy learning takes place or the timing of any resulting changes, if any. The literature on policy learning also suggests that one of the largest criticisms lies in proving that it occurred when there is no evidence of policy change. In other words, policymakers may have widely performed jurisdictional/environmental scans to seek out 'best practices' and have therefore "learned", but still not have made the decision to copy, emulate or otherwise incorporate their learning into a policy of their own, despite it being labelled the 'golden standard.' There is a lack of literature on addressing case studies, specifically comparatively, in which learning may have occurred but there may be obstacles such as leadership who was against it, organizational pressures, and institutionalized pressures. In other words, while there certainly could have been an awareness of existing newly up-to-date policy information, due to barriers, were ultimately not utilized within a jurisdiction.

As mentioned above, the literature on policy learning is quite ambiguous and the consideration of how timing impacts the scope of policy change remains underexplored in the existing literature. Thus, there is a need to recognize and study the multiplicity of learning outcomes, even if it does not directly result in identical or very similar forms of policy change (Moyson & Scholten, 2018).

(d) Policy Entrepreneurs

Interests refer to "agendas of societal groups, elected officials, public servants, researchers, and policy entrepreneurs" (Lazar et al., 2013). This reflects the assumption that policy developments and choices are largely driven by the real or perceived interests of various stakeholders, their desire to influence the policy process to achieve their own ends, and the power of relationships between stakeholders and governments (Peters, 2002: 553). They describe the preferences and power embedded in policy actors. Behaviouralists assume that policy outcomes are largely determined by actor interests and behaviours (P. Hall & Taylor, 1996). The ability of actors to attain and exercise their interests depends largely on the distribution of resources and power in a policy domain, as well as individual capacity and skills.

How, and under what conditions, do these contested interests become viable political and/or policy solutions has been a key question on agenda-setting in the public policy literature (Kingdon, 1984). Policy entrepreneurs play a vital and intermediary role in these processes by acting as agents of change in which they prepare and refine solutions and then promote them when opportunities arise. The concept of policy entrepreneurs is not only attractive due to the role of agency in understanding policy change, but because it also provides a potential alternative and more nuanced explanation to the portrayal of the role of purely rational actors within policy-making processes. John Kingdon's (1984) **The Multiple Streams Framework (MSF)** serves as a powerful tool for analyzing policymaking across various policies and countries through three separate streams: **problem, policy, and political.**

(a) The **problem stream** is filled with perceptions of problems that are viewed as "public" in the sense that government action is required to resolve them. These problems usually get the attention of policymakers due to dramatic events such as crises or through feedback from existing programmes that attract public attention.
(b) The **policy stream** is filled with the output of experts and analysts who examine the existing problems and propose solutions. Within this stream, a myriad of possibilities for policy action and inaction are identified and discussion and then narrowed now to a subset of ostensibly feasible options.
(c) The **political stream** comprises factors that influence the body politics such as swings in national food, political leadership turnover, and interest group advocacy.

Kingdon (1984) clarifies in his work that these three streams flow along different channels and remain more or less independent of one another until at a specific point in time a policy window or the *window of opportunity* opens up usually for a short period of time through the facilitation of a policy entrepreneur. It is only in this instance that the three streams cross paths.

Building on his own MSF, Kingdon (2010) poses that many different solutions exist on any given policy issue. Thus, his key question then becomes why one policy solution is chosen over another. Unlike the assumption of pure rational actor models, decision-makers in the MSF may experience shifting preferences for policy. [4] These changes can occur based on current (limited) information that may be superseded with new information, new ideas or because the timing for making a decision changes or is compressed. For example, in cases of emergencies that need to be dealt with immediately, decision-makers will rely on whatever information is readily available. The problem stream refers to all the existing issues that may be considered before any action occurs, whereas the policy stream is related to all the alternative and possible solutions to solve a problem. Finally, the political stream represents the attitudes and ideologies of both the public and the decision-makers.

The crucial aspect to understanding the MSF approach is that these three streams flow independently of one another until a window of opportunity is presented through the facilitation of a successful policy entrepreneur. The concept of policy entrepreneurs is attractive not only because it foregrounds the role of agency in understanding policy change, an area that Peters (2015) argues has been neglected, but because it provides an alternative agency-centred explanation to purely rationally acting actors in the policy-making decision-making processes. Policy change is a political reality that is impossible to grasp without paying attention to human agency (Parsons, 2007) and more specifically, the mobilization of specific actors involved in the policy-making process (Genieys & Smyrl, 2008).

Policy entrepreneurs are broadly defined as individual or collective energetic actors who can work inside or outside of government and that seek policy change through shifting the status

[4] Kingdon makes two assumptions in support of his argument concerning the importance of policy entrepreneurs and the lack of pure rationality: First, the ambiguity in problem definition prevents rationality from being useful. Thus, different actors define the same problem differently, so goal maximization is impossible. The second assumption is that there is limited time and resources, therefore, individual decision-makers only have so much time and capacity to tackle select number of them in a world that is full of endless ones.

quo in given areas of public policy (Kingdon, 1984; Mintrom, 2015). Since Kingdon's initial work, the literature on policy entrepreneurship has exploded and become much more sophisticated. Policy entrepreneurs come from diverse occupations and backgrounds working in the public, private, and non-profit sectors (Botterill, 2013; Huitema & Meijerink, 2010). They are distinguished from other actors in the political process by the intensity and duration of their efforts to promote their preferred policies (Arnold, 2021). At the core, policy entrepreneurs are individuals who seek to initiate dynamic policy change (Baumgartner & Jones, 2009; King, 1989; Kingdon, 1984; Polsby, 1984), through gaining support and traction for policy change. They achieve this through various methods, such as (or including) networking, problem identification, shaping the terms of policy debates, and building coalitions.

Given the relative 'vagueness' of identifying a policy entrepreneur, many frameworks have tried to capture the distinguishing attributes of a policy entrepreneur or entrepreneurship.[5]

[5] Roberts and King (1991) who state that policy entrepreneurs:

(a) generate ideas;
(b) frame problems;
(c) disseminate information in a strategic manner;
(d) use demonstration projects to show policy viability;
(e) develop ties with bureaucratic insiders and policy influencers outside of government;
(f) enlist support from elected official, lobby, seek media attention; and
(g) pursue policy evaluation;

Mintrom and Norman (2009) also define policy entrepreneurs:

(a) create community insight to take advantage of windows of opportunity;
(b) effectively defining (and redefining) problems;
(c) work well with others as team players; and
(d) lead by example to reduce perceived risks for the group.

With some degree of overlap with these two categorizations, Brouwer & Huitema (2018) argue that policy entrepreneurs engage in:

(a) attention and support seeking;
(b) seek to link people to one another and to the focal issue;
(c) manage interpersonal relations; and
(d) strategically choose venues and advocacy timing.

Cairney (2017) states that policy entrepreneurs use the following strategies:

(a) Tell a persuasive problem to frame a policy problem;
(b) Make sure that their favoured solution is available before attention lurches to the problem;
(c) Exploit a window of opportunity during which policymakers have the willingness and ability to adopt their policy solution

Rather than simply define policy entrepreneurs by certain characteristics or activities, Arnold et al. (2023) explored what characteristics set policy entrepreneurs apart from other policy actors. Their list included:

From this discussion, there are four main characteristics of entrepreneurship that, to some extent, overlap in the literature:

(a) Possessing expertise or knowledge;
(b) Being well connected to government officials;
(c) Being well connected to other policy advocates;
(d) Being well connected to other members of the media (Arnold et al., (2020); Aviram et al. (2020))

Arnold et al. (2020) proposes a minimum threshold definition for identification of a policy entrepreneur as being one in which individuals involved in the policy decision making process, either through surveys, focus groups or interviews, identify a particular policy actor as possessing at least one of these four characteristics and acting in the manner of an entrepreneur.

The attempts to define and identify policy entrepreneurs has tended to be singular in focus. However, Beland and Haelg (2020) argue that the original definition of policy entrepreneurs popularized by Kingdon (1984, 2011), which stresses the role of individuals in the policy process, may not be applicable to certain or all cases, particularly where there are collective agents or actor networks. Instead, they highlight that there are different types of entrepreneurs and distinguish individual policy actors from collective ones, including:

(a) networks;
(b) advocacy coalitions;

(a) Invests time frequently in advocacy and/or their reputation
    a. In terms of frequently, they engage in advocacy few times or once a week or more;
    b. Engage in advocacy for 5 or more years;
    c. Spending more than 5% pf their annual budget on advocacy;
    d. Their names have been identified by at least one other survey respondent who they have worked with
(b) Motivation – meaning they aim to get government officials to adopt policies, pay attention to specific policies
(c) Strategies:
    a. Raising public awareness;
    b. Building teams or networks;
    c. Pilot or demonstration projects;
    d. People skills;
    e. Drawing ideas and resources from various sources;
(d) Expertise or knowledge
(e) Well-connected to government officials, policy advocates and media
(f) Relational attributes (where they operate in a policy network, how, and with whom); the extent in which an individual pursues advocacy with partners

Additionally, to further reconcile with the concept of policy entrepreneurs, Aviram et al (2020) conducted a meta-analysis of 229 articles which identified 20 policy entrepreneurial activities and identified three distinctive traits of policy entrepreneurship: trust-building, persuasion, and social acuity (Frisch Aviram et al., 2020).

(c) epistemic communities; and
(d) instrument constituencies (Béland & Haelg, 2020).
(e) Iron triangles

While some may still draw a distinction between them (i.e. Atkinson & Coleman, 1992), the concept of policy networks has been used interchangeably since the 1980s-1990s with 'policy communities' or 'interest groups' (Oliver & Acuto, 2015). Networks can help visualize how interests, embedded in nodes, are structured in the policy process and how network structure changes as actors form and dissolve relations. Networks are defined conceptually as a set of actors and their relationships, and as intentional governance or management structure with agency to act strategically and produce policy outcomes (Shearer et al., 2016). Networks, like institutions, can impose structural constraints on policymaking by mediating pattern of relations among actors (Marsh & Smith, 2000). However, they are more fluid in that they are more likely to change in response to institutional pressures by creating new opportunities and incentives for policy interactions. Also similar to institutions, networks can influence power dynamics by choosing to include or exclude participants (Marsh & Smith, 2000). As a result, networks have the ability to create, reinforce, challenge, or otherwise constitute institutions by facilitating interactions among actors in ways that might shift norms, preferences, and power (Hall & Taylor, 1996). Actors embedded in the networks have agency to decide who they will interact with, conscious and strategic decisions that can shape networks to help advance certain interest and control information exchange. Thus, networks play an important role in the creation, dissemination, reinforcement and rejection of ideas.

According to Sabatier, advocacy coalitions consist of "people from a variety of positions such as i.e., elected and agency officials, interest group leaders, researchers) who share a specific belief system such as i.e., set of basic values, causal assumptions, and problem perception – and who show a nontrivial degree of coordinated overtime" (Sabatier, 1988). Coalitions interact within policy subsystems, defined simply as a broader set of actors who are involved in dealing with a policy problem (Sabatier, 1998: 138). It includes varying numbers of coalitions, ranging from one to four, and policy brokers whose roles are to minimize conflict and produce workable compromises between coalitions, and a "sovereign" or "government authority" to make policy decisions and oversee the policy-making infrastructure.

Epistemic communities, a concept derived from 'soft' constructivist scholars in international relations are concerned with agency to understand the actors that are associated with the formulation of ideas, as well as the circumstances, resources, and mechanisms by which new ideas or policy doctrines get developed and are introduced to the political process (Haas, 2001). Epistemic communities are networks – which consist of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant within that domain or issue-area (Haas, 1992: 3). A more recent concept in policy analysis, instrument constituencies are defined as "networks of heterogenous actors" (Béland & Howlett, 2016) which "define policy alternatives and instruments" (Mukherjee & Howlett, 2015). Public policy theories generally do not consider 'experts' as a homogenous group which are separate from business and government. Rather, they are integrated within a less-defined permeable group of actors such as epistemic communities, as well as issue networks, policy communities, policy networks or advocacy coalitions.

Iron triangles or 'issue networks' were described by Gordon Adams (1981) as the policy-making relationship among congressional committees, the bureaucracy, and interest groups (constituencies or non-state actors). Initially influenced by US politics, the notion of the 'triangle' is that one corner of the triangle are powerful interest groups that have the ability to influence Congressional votes in their favour and can sufficiently influence the re-election of a member of Congress in return for support of their programs. In the case of health policy, the parallel of this dynamic would be observed by physicians and their respective medical associations. Physicians are uniquely qualified and positioned to exercise influence in health policy due to their medical and healthcare expertise. Through their medical associations, physicians hold the ability to advocate for policy changes, which in turn, allow them to influence legislation, regulations, as well as healthcare delivery practices within all levels of government (Landers & Sehgal, 2000). Medical associations and physicians alike are effective lobbyists and as a result, hold the ability to lobby policymakers on behalf of their members, which allow for the shaping of policy discussions that work in the favour of physicians (i.e. billing, physician reimbursement, etc.). In the case of mental health policy, this power and privilege would apply to physician providers such as family physicians and psychiatrists (Trebilcock, 2022). On the

other hand, this same privilege would not be applicable to allied non-medical mental health professionals (i.e. psychologists, psychotherapists, social workers, occupational therapists etc.) as they do not have the same access to policymakers and ability to lobby or advocate through their respective associations (Mulvale et al., 2007).

While these concepts may not negate the role of individuals in policy process, they point to a broader conception of agency beyond that of individual agents as the term 'policy entrepreneur.' This is because the term 'entrepreneur' typically refers to individuals rather than groups (Béland & Haelg, 2020). However, that is not to say that policy entrepreneurs do not engage with other individuals or groups, as a large part of successful policy entrepreneurship is engaging with new and existing networks. The role of entrepreneurship is surrounded around relationship-building and people skills, thus, 'social skills' are an essential trait for policy entrepreneurs to have to successfully promote potential policy solutions during a 'policy window.' Building on this, timing is crucial for policy entrepreneurs, whether individual or collective actors, as they need to be ready to seize opportunities to promote preferred policy solutions with competing priorities and agenda items during the short policy window.

Lessons Learned on Interests and Policy Entrepreneurs

I view interests broadly "as agendas of societal groups, elected officials, public servants, researchers, and policy entrepreneurs" (Lazar et al., 2013) and emphasize a degree of agency in policy making processes. However, critiques of these explanations surrounding the consideration of how policy entrepreneurs fit conceptually into the theories of the policy process are namely around its 'fuzziness' - meaning that it means different things to different scholars, even within the same discipline (Cairney, 2013; Petridou, 2017). While I recognize these criticisms and the difficulties inherent in identifying an "entrepreneur", Arnold et al. (2023) makes a serious attempt at reconciling these concerns through deeper considerations of the concept, such as a low-profile entrepreneur vs. an elite entrepreneur as well as a successful entrepreneur vs. a non-successful entrepreneur. Arnold et al. (2023) claims that all these individuals are all considered entrepreneurs. This leads to a second critique which is that the focus on policy entrepreneurs as individuals can potentially lead to consideration of too many

forms of political actions as being considered 'entrepreneurial' activities. This can lead to conceptual overstretching of "entrepreneurship" and that can be detrimental to a more nuanced understanding of the specific and exclusive functions of different types of agency in the policy process.

Béland & Haelg (2020) give credit to Mintrom and Norman (2009) for pioneering the gap in the policy entrepreneurship literature regarding how policy entrepreneurs are and should be distinguishable from other actors. What started as a loose metaphor has evolved into a more sophisticated concept. Ironically, the early emphasis placed on individuals as change agents appears to have served as an inhibitor to theorization. In any instance of policy change, it is usually possible to locate an individual or a small group of individuals who are at the forefront of driving action for policy change. Yet, in all of these cases, these individuals, their motives, and their ways of acting appear idiosyncratic – which Mintrom and Norman (2009) acknowledge offers favourable grounds in theory. Thus, to overcome this barrier, they proposed that there is a need for policy entrepreneurship to be studied in a manner that pays attention to contextual factors, individual actions within those contexts, and how those contexts shape actions. These critiques can, however, also be addressed through further research in five specific areas in terms of demonstrating how policy entrepreneurs drive public policy change:

> (i) delimiting policy entrepreneurs as a distinct class of actors from broader conceptualizations of collective policy actors;
>
> (ii) investigating contextual factors that encourage the emergence of policy entrepreneurs;
>
> (iii) further specifying the strategies that policy entrepreneurs employ;
>
> (iv) improving the measurement of the impact policy entrepreneurs have in the policy process; and
>
> (iv) identifying when policy entrepreneurs prompt widescale change versus smaller scopes of change (Petridou & Mintrom, 2020).

From an epistemological perspective, nuance is required in the identification of who is and is not a policy entrepreneur (Petridou & Mintrom, 2020). As an initial step, the Identification of policy entrepreneurs is subject to a number of concerns. For example, consideration of who

constitutes a policy entrepreneur must be based on qualitative criteria, and with the attendant risks of biases. Additionally, being classified as a policy entrepreneur has been primarily considered as dichotomous – either one is or is not, as well as whether policy change has occurred or not. Greater nuance over entrepreneurship could show the potential for entrepreneurs to have varying degrees of success within a policy space and thereby making them less visible at times, yet remain entrepreneurial.

Despite the criticisms of the theory, as Pertridou & Mintrom (2020) state, policy scholars, political scientists, and many individuals who have a desire to achieve policy change could certainly benefit from understanding and exploring new insights into what policy entrepreneurs do – and how and why their actions make a difference. In addition, there is still the need to be able to differentiate policy entrepreneurs from other policy actors that may have been present but did not play a visibly entrepreneurial role or have much influence in the policy-making process. Arnold et al. (2023) attempts to remedy some of these concerns in also exploring the identification of a policy entrepreneur and differentiating them from other types of policy participants. They introduce some methodological options that would prove useful in how researchers might distinguish policy entrepreneurs from other actors, including media analysis at the local level and/or surveying elites or experts about influential actors in policy processes (Arnold et al., 2023). Another way researchers may identify policy entrepreneurs is through in-depth documentary analyses – i.e. review of media content, advocacy materials and/or policy documents (Maurya & Mintrom, 2020; Petridou et al., 2021).

Other barriers that Arnold et al. (2023) explore is the difficulty in locating more "low-profile" policy entrepreneurs versus elites and less successful policy entrepreneurs versus successful ones. This is evident in both of my empirical case studies – where in Ontario, we hear about the successes of policy entrepreneurs and it was in turn much easier to identify them, whereas, in BC, there were actors who advocated for the adoption of a more comprehensive and publicly funded psychotherapy program but were ultimately unsuccessful in doing so. Arnold et al. (2023) tries to reconcile the initial by trying to identify and understand that some policy entrepreneurs may lack the political connections or expertise of entrepreneurs who are nominated by their elite networks or informants, but still nonetheless made efforts to influence

policy. Arnold et al. (2023) acknowledge that this is proven to be difficult as these individuals are less likely to be in the media and less likely to be interviewed, which in turn, means they are less likely to be identified.

Conclusion

In conclusion, complex or complicated policy systems consisting of institutional legacies and a wide range of, and sometimes competing, actors in dynamic and changing policy environments provide challenges for understanding policy stability and change. While the existing literature on different theoretical frameworks, such as ideas, institutions, learning and policy entrepreneurs, provides potential explanatory variables to what influences policy change in health and mental health policy, it is unrealistic to believe or conclude they all serve as the primary and/or independent explanations for why policy change occurred.

It is also apparent that these theories "overlap" with one another rather than operating in siloes and it is expected that some evidence for each can be found in the dynamics of most policy spaces. For example, ideas are present in the institutions, learning, and entrepreneurship literature as well as representing an explanatory factor on its own. Institutions may act as forces of power that *prevent* or constrain new ideas from entering the policy space and achieving policy change or that they may serves as opportunities or enablers for the same. In turn, policy entrepreneurs who are known as "change agents" or "ideas carriers" may not be able to successfully overturn existing institutional ideas with new ideas and/or learning, if there is an absence of *window of opportunity* or an individual is not as viewed as or is it not sufficiently influential (i.e. weak networks, not well-known in the space etc.). This may be a strong barrier in a traditionally hierarchical policy space such as health policy (i.e. medical providers vs. non-medical providers). While persuasion and strategic skills are outlined in the literature as characteristics of a successful policy entrepreneur, in which they are able to appropriately frame an existing policy problem to achieve "buy-in" from stakeholders and beyond to achieve policy change, there is a need for greater consideration that while an individual may possess all the traits to successfully pursue change, but if they are acting within a traditionally hierarchical (ie. institutionalized) policy space and they do not "fit the mould," despite possessing all the traits

that one has to be a successful entrepreneur, it may still prove to be difficult to achieve buy-in for the new ideas. Alternatively, if an entrepreneur is someone with strong ties, influence, and a strong reputation in the space, they may be able to achieve policy change despite pre-existing institutional frameworks. Entrepreneurs in these instances not only act as ideas carriers but also as individuals who present opportunity learning to be translated into new ideas and then hopefully, policy change. Policy learning is as indicated in the literature one of the most complex and difficult to observe as it can occur without resulting in policy change or where there is only limited scope of change. The reasons for this are nuanced as it may be due to lack of support, or the power of the specific professional group may act as a strong barrier to achieving policy change, despite learning having occurred. Thus, the permeability of these institutional factors, acting somewhat like 'iron triangles', is an important factor to consider. For example, some professional associations, particular in the healthcare space, such as physicians, hold greater bargaining power and 'have the ear' and access to policymakers which may not necessarily be the case for other healthcare providers i.e. allied mental health professionals such as social workers, occupational therapists and others. Similarly, in the case of policy entrepreneurs, while an individual may not traditionally be "part of an influential professional association" if they have strong ties or have built a career within the bureaucracy and are "familiar with the rules of the game," this may serve as a significant advantage in which they may be able to utilize to influence policy change. Achieving policy change as both an individual and professional association has been proven difficult in cases such as non-medical allied mental health professionals where there are traditionally weaker ties with the bureaucracy.

These different theoretical entanglements in political science suggest that policy change is both complicated and takes place in complicated spaces. A single variable does not suffice in providing a fulsome explanation and I expect to find evidence of ideational change affecting and being affected by existing institutional circumstances and the actions of policy actors in pursuing policy change in Ontario and British Columbia in the mental health policy space. In some cases, I expect that a dynamic and changing ideational context, often perceived as a crisis, provides immediate space for policy change, but only for so long as the new understanding or priorities

in the policy space remain fixed. In some of those circumstances, policy change may happen rapidly as policy actors reach for available solutions to the new problem or crisis, often learning or borrowing from other jurisdictions. Policy change in these immediate circumstances may be limited in scope and subsequently blunted by a lack of visible and/or successful policy entrepreneurship and institutional legacies (such as a lack of buy-in from or professional jurisdiction protection by other medical and non-medical mental healthcare providers) or the emergence of other "new" priorities that constrain the acceptance of new ideas, the perceived need for greater involvement by governments and the scope of change overall. In other circumstances, a changing yet more stable ideational context coupled with strong policy entrepreneurship and an institutionally more receptive policy space provides greater opportunity and ability to overcome institutional constraints, albeit over a longer period of time, but with greater overall scope of change. Underlying and coinciding with these dynamics of ideas, institutions and entrepreneurship is the receptiveness to policy adoption from other jurisdictions that, to differing degrees, also influences the scope of change pursued. What comes from this is not a simple story of what takes place in complicated and complex policy environments facing demands for government action, such as in the mental health policy sphere. Instead, policy change, when driven by changing ideational understandings and priorities and the presence of a crisis is quite messy and requires long, dedicated periods of consideration to truly understand the changing ideational contexts, roles of institutions and policy entrepreneurs, and knowing whether policy learning took place or not.

CHAPTER 3: METHODOLOGY

I. RESEARCH QUESTIONS

This chapter sets out the methodological approach to answer the broad question: Under what conditions do jurisdictions achieve different levels or distinct scopes of policy change in general and, particularly in relation to the health and mental health policy spaces, and at different speeds or times? This research question will be explored through two separate and comparative examinations focusing on mental health policy change in two Canadian provinces (Ontario and British Columbia) and using a process tracing approach. Despite facing similar, if not identical policy challenges and environments, policy change occurred in the mental health policy field in both jurisdictions, albeit at different times and in differing degrees of intensity or scope. More specifically, it will seek to understand:

1) What conditions allowed BC to develop an early, low-intensity program and deterred them from adopting a larger-scale province-wide program?
2) What conditions blocked early policy development in Ontario, but allowed for a larger-scale program at a much later date?

This chapter establishes the methodological approach to exploring these questions of policy change, particularly in relation to the under-explored questions of timing and scope of change that differed between the two provinces (Boothe, 2011; Tuohy, 2018). First, it sets out and justifies the use of the comparative method and a process tracing approach to the case studies of Ontario and British Columbia. Second, it provides a justification for why health policy, and mental health policy in particular as a complicated policy sphere, is an ideal policy space to explore questions of timing and scope of policy change and includes a brief summation of the health policy literature on this subject. Third, an overview of Canadian mental health policy system is provided, followed by a justification for my two selected case studies, Ontario and British Columbia. Finally, I provide an overview of how I define the theoretical terms: ideas, institutions, policy learning and policy entrepreneurs to set the stage of how to examine the possible explanations for policy change at different times and differing scopes.

II. THE RESEARCH METHOD - A Comparative Case Study Approach to Understanding Policy Change

This dissertation focuses on the comparison of two case studies of two Canadian provinces, Ontario and British Columbia, that were undergoing similar policy problems, at the same time, and with similar competing policy environments and political constraints to explore the differences in mental health policy outcomes. These two provinces share important causal and contextual factors but exhibit variation and differences in policy outcomes, in terms of both timing and scope of change, and thus present as a natural experiment in understanding the various factors associated with policy change and stability. Thus, this dissertation uses the comparative method as Simeon's (1976) seminal piece *Studying Public Policy* argues that public policy "needs to be comparative" whether it is across policy fields, subnational units, national units, regions or even across various levels of government (Boychuk, 2016; Simeon, 1976) There are four reasons for this: first, the goal of public policy being policy analysis and explanation rather than policy description; second, the analysis of public policy requires a holistic and contextually situated analytical framework; and third, theory-building requires more than a single case study. Individual case studies have a tendency to be isolated and unique, as they each look at different issues, different methods and ask different questions (Boychuk, 2016). Finally, there is added complexities in exploring policy change in single case studies, which may not be the case for comparative case studies, as the latter allows researchers to isolate key explanatory factors that might otherwise get "overlooked" or "lost" in single case studies.

This research project uses Mill's (1843) methods of the most similar systems design or 'method of difference' which is predicated on comparing very similar cases which differ on the dependent variable(s), which in this case, are scope and timing of policy change. These two cases are 'similar systems' within Canada which had different outcomes in terms of the timing and scope of policy change. Ontario made the decision to pursue a province-wide publicly funded psychotherapy program, whereas British Columbia which had the expected conditions to do so but did not. In addition, British Columbia moved quickly to address the mental health crisis while it took Ontario more than a decade to develop a public mental health program.

This dissertation uses process tracing, a deductive procedure in which the researcher looks for evidence of a "series of theoretically predicted intermediate steps" (Pierson, 2004b). Process tracing is a fundamental analytic tool of qualitative analysis which has the ability to contribute to both describing political and social phenomena and to evaluating causal claims (Collier, 2011). Given its close engagement with cases and centrality of fine-grained case knowledge, process tracing can make large contributions to diverse research objectives such as "(a) identifying novel political and social phenomena while systematically describing them; (b) evaluating prior explanatory hypotheses, discovering new hypotheses, and assessing these new causal claims; (c) gaining insight into causal mechanisms; and (d) providing an alternative means – compared with conventional regression analysis and inference based on statistical models – of addressing challenges such as reciprocal causation, spuriousness, and selection bias" (Collier, 2011).

George and Bennett (2005) define process tracing as "the method [that] attempts to identify the intervening causal processes – the causal chain and causal mechanisms – between an independent variable (or variables) and the outcome of the dependent variable" (206). The method of process tracing was originally proposed to incorporate historical narratives within highly abstract theories and explanations in the social sciences. In the field of political science, specifically, early definitions of process tracing were provided by George and McKeown (1985) who defined it as a method of "within-case" analysis to evaluate causal processes. George and Bennett (2005) have led the development of this method as an essential form of 'within-case analysis,' which allows for the control of a smaller number of cases. Hence, process tracing is best used to complement analyses of congruence for single cases and comparative cases (two or more). This method draws on descriptive and causal inferences from diagnostic pieces of evidence – often understood as part of temporal sequence of events (Collier, 2011). The focus on longer periods of time is particularly important in trying to understand policy change in the context of complicated policy systems suffering from "wicked" and "wicked-like" problems. The changing or shifting ideas that constitute and reconstitute both priorities and policy problems, coupled with the roles of actors and the difficulties in observing learning suggest a deep qualitative and longitudinal approach focused on smaller numbers of cases. As a result, my research uses small-N case studies, and a process tracing that is useful as it is able to strengthen

casual inferences of comparable cases and will permit the examination of the causal factors that led to scope of policy differentiation (Collier, 2011).

III. THE POLICY SPHERE CASE - Mental Health Policy as a Case Study for Policy Change

The field of health policy and more specifically, mental health is an ideal policy space to explore the timing and scope of policy change because it is rich in terms of examples of robust and significant policy change, coupled with:

i. Competing, evolving and intersecting ideas on the nature of illness and illness priorities, the availability and appropriateness of treatments and the range and professional stature of appropriate treatments providers;
ii. a corresponding multitude and multi-level of institutional based interests;
iii. a wide range of policy actors; and
iv. evolving understandings of treatments and programs across the world that provide opportunities to learn and borrow from both within and outside of jurisdictions.

In addition, both health policy in general and mental health specifically are also highly salient policy spaces to the public and therefore warrant further investigation and understanding.

Mental health is a complicated sector of the overall healthcare policy system that has historically been overlooked and "othered" within the healthcare system (Bartram, 2017). From early ideas regarding institutionalization, which focused on hospital-based care and severe mental illnesses, to the transition to community-based treatment, as well as mild to moderate forms of mental illnesses such as depression and anxiety, the ideas of what mental health is has changed significantly over the course of several decades (NHS, 2018). Additionally, the ideas regarding the types of available and acceptable forms of mental health treatment has changed within the field as well, particularly as new understandings of illness become known or learned and new treatments are discovered or rediscovered. What initially started with a focus on institutionalization and a large focus on medication from the field of psychiatry has now changed to different forms of psychotherapy, also known as "talked-based therapy", and which

research has shown is as effective, if not more effective, than prescription medication in certain cases (American Psychology Association, n.d.).

These evolving ideas on illness and treatment have further complicated the mental health policy space in terms of service providers. Initially, the field of mental health, which was dominated by hospital-based care, was primarily delivered by psychiatry as well as psychology. Even between those two fields tensions existed primarily regarding public health coverage (which the field psychiatry and family medicine had and psychology often, did not) (Mulvale et al., 2007). To date, in addition to psychologists, there are several other non-medical allied mental health professionals such as psychotherapists, social workers, and occupational therapists who can also provide non-medical mental health services (i.e. psychotherapy), which has furthered complicated the space as well as added tension regarding who can, should, and/or is considered best positioned to deliver non-medical mental healthcare services.

Additionally, the existing literature and research conducted on mental health has traditionally come from fields such as psychiatry, psychology, public health, and sociology. When it came to empirically based and provincially focused case studies, the literature was even more lacking. Most of the existing literature in Canadian mental health policy focuses on the federal context of Canada as a whole or single provincial cases, primarily Ontario (Farmanara et al., 2016b; Mulvale et al., 2007). Next, in addition to filling a large gap in the literature on mental health in the public policy space through a comparative provincial case study, the field of mental health, like many other areas of public policy, similarly experiences the presence of stability and policy change, complicated policies and interactions, and a wide range of actors from a multitude of professional backgrounds.

These challenges in the mental health policy space have, not surprisingly, been subject to broad academic consideration and without resolution on the scope and timing of change concerns. This wide body of literature in the mental health field employs similar methodologies and theoretical frameworks from public policy and political science, such as policy legacies, role of ideas, policy learning, and policy entrepreneurs. Thus, there is an expectation that the gaps and issues found within the public policy literature will also be present in the health policy and mental health literature as well, including a lack of resolution on the timing and scope of change

questions. Accordingly, this section provides a limited examination of the same public policy frameworks from chapter two but builds on it by applying it to a health policy and mental healthcare research. It is evident that as identified from the previous chapter that the same gaps in explanation and complications evident in the public policy literature are equally present in health policy and mental health research and that, as such, this policy space is one that can help illuminate the key factors effecting the scope and timing of policy change.

(a) Ideas

The role of ideas has been applied within the health policy context and mental health and underlies both the causative and constitutive effects of ideas. Mulvale and Bartram (2015) discuss how ideas in health policy can be a key lever in transforming mental health policy and delivery (44). They argue that the 'deinstitutionalization era' in the 1950s came from and gave rise to new ideas around shifting understandings of the nature of mental illness and the appropriate treatments provided by mental healthcare from the fields of psychiatry and psychology, such as asylums to community-based mental healthcare. Initially, the field of mental health was dominated by the field of psychiatry given physicians were granted privileges through public health insurance as well as strong support from their respective medical associations. In addition, the understanding of mental health, at the time, was primarily focused on severe or more serious mental health conditions rather than mild to moderate mental health conditions such as depression and anxiety. Since then, coupled with the ongoing evolutions of various mental illnesses and the discovery of new medications as alternate forms of acceptable treatments, these new ideas and understandings have helped overcome policy legacies focused on separation and institutionalization, and led to a paradigm shift that transformed mental health policy and delivery of services altogether (Mulvale et al., 2007).

During the 1970s, the idea of recovery-oriented mental healthcare services further gained significant traction. It proposed that people with mental health should have the right to have greater control and responsibility over their life, not just as patients, but also possibly as functioning members of society (Mulvale & Bartram, 2015). This led to a paradigm shift from a primarily biological to a more holistic bio-psycho-social-spiritual understanding of mental health illness and recovery, as well as leading to the emergence of a professional psychiatric

rehabilitation movement that recognized the value of community and work in the lives of people with mental illnesses.

More recently, mental health policy has embraced the idea of well-being, with a view of improving the quality of life, reducing the burden of disease, and increasing economic participation and productivity (Government of the United Kingdom, 2008). The concept of 'well-being' originates from the field of public health, which focuses on population health and preventive care and refers to improving the overall mental health of a population as well placing emphasis on the potential return on investment on investing in early intervention mental health services, which will result in cost savings on healthcare resources (i.e., physician and hospital visits) as mental health imposes a substantial financial burden on the economy due to loss of work productivity and disability (Moroz et al., 2020; see also Canadian Institute for Health Information, 2011; Health and Warfare Canada, 1986; World Health Organization, 2005). Coinciding with this has been an increased focus on less severe forms of mental illness that affect larger populations, such as anxiety and depression.

Mulvale et al. (2007) suggests that the power of 'changing ideas' regarding the best methods to treat mental illness may play a key role in being able to move mental health policy towards new paths of development. Her study, however, like on Canadian mental health policy, notes the limitations of only examining the experience of changing and evolving ideas of mental illness and appropriate forms and types of care (and the correspondingly relevant treatment providers) in Ontario. Thus, they also suggest the benefits of a comparative study as comparing the importance of changing ideas between jurisdictions within similar mental health system structures and the resulting policy and delivery changes may bring greater clarity to the importance of ideas in influencing the changes in mental health policy.

(b) Policy Legacies

Path dependency and policy legacies have also been found to have played a strong role in shaping Canada's mental health policy regime. In Canada, provincial and territorial governments are primarily responsible for the delivery of their populations' healthcare needs. Under the 1984 **Canada Health Act (CHA),** only healthcare services provided by physicians or within a hospital-based setting are covered through public healthcare insurance or Canadian Medicare. This means

services provided by allied mental health professionals such as psychologists or social workers fall outside of CHA's cost-sharing arrangement and, as a result, are often paid for by citizens through out-of-pocket or third-party work insurance.

This legacy is a consequence of the early decisions from government regarding neglect towards mental health, such as those made in 1957, when the Canadian federal government passed the **Hospital Insurance and Diagnostic Services Act (HIDSA)** which offered to reimburse or cost share one half of provincial costs for specified hospital and diagnostic services, in which mental health hospitals were excluded from the benefits (Bartram & Lurie, 2017; Government of Canada, 2011). Despite heavy and long heated debates, the decision to exclude mental health hospitals from public health coverage was ultimately upheld through the **1968 Medical Services Act.** This decision was justified based on recommendations from the government-appointed Hall Commission to shift mental health care from asylums to community-based care and general hospitals. By the 1970s and 1980s, the federal role in mental healthcare services diminished with the shift from cost-shared to block federal health transfers, the federal share of health began its slide from 50 percent of total health insurance costs (which continued to go down to 9% in 2001 and back up to 21% in 2014) (Bartram & Lurie, 2017). In exchange for this reduced federal share, provincial and territorial governments gained increased autonomy over decisions as to how to allocate the funds (Ouimet, 2014). The CHA could have responded to the growing need for broader health insurance by expanding coverage beyond physician and hospital-delivered healthcare (i.e. psychologists) during this time period but instead, only addressed the issue of extra billing and thereby continued the split between public and privately funded access to psychotherapy.

Mulvale et al.'s (2006) findings demonstrate that early decisions made with the development of the CHA produced both psychiatric and hospital-based legacies that made achieving broader mental health reform difficult. In particular, physicians became a powerful force in the healthcare policymaking sphere through their respective medical associations and in turn, became direct participants in health policy making. In contrast, other allied non-medical mental health providers did not have the same access to power in decision-making and/or bargaining power lacked the

same level of influence and impact, particularly in policy spaces subject to professional regulation that permits a degree of control over the provision of services (Trebilcock, 2022).

In some circumstances, the recognized expertise provides for a “common sense” allocation of resources. For example, provincial public health insurance covers mental health services provided by physicians, including both family physicians and psychiatrists. This advantage created a legacy that limited the availability of resources and placed allied mental health professionals, such as psychologists, at a significant disadvantage. For example, when hospital budget cuts took place, psychologists were hit particularly hard, whereas physicians whose services were covered through public health insurance plans (i.e. OHIP in Ontario and MSP in BC), were covered through the insurance plans, whereas, for psychologists, their salaries were paid by the hospital budget (Mulvale et al., 2007). In other words, this lack of access to policymakers and bargaining power was particularly visible during financial difficulties. In contrast, the boundary controlling regulatory aspects of professional accreditation also provides a degree of legitimacy to policy makers for some practitioners and not others in the mental health policy space (Trebilcock, 2022). Similar to the funding aspects, this provides greater access to and authority in dealing with governments, particularly in relation to the recognition aspect of treatment and care.

(c) Policy Learning

Despite the lack of analytical clarity, policy learning has also been found to be a key element in health policy, albeit in a more negative context in some circumstances. For example, Sheikh et al. (2020) cite Dunlop's (2017) concept of policy learning in finding that health systems that do not learn from others or their own experiences’ can often repeat mistakes. This lack of learning or feedback effects has often been the root cause of well-intentioned policies and programs to fail.

In contrast, the idea of utilizing learning in healthcare systems has also been found to be beneficial as different systems often share many similar institutions and policies (and corresponding challenges and problems) across the world. On the funding side, governments all generate or collect revenue in a multitude of ways (collect taxes, contributions for social insurance, premiums for private insurance and direct patient payment) for the provision and delivery of medical care. All healthcare systems, to some degree, are a mixture of public and

private provision of healthcare services. Furthermore, the health policy goals on industrialized nations and emerging economies remain the same: they want to safeguard access to high quality healthcare for all. Particularly in the case of 'similar' Westminster countries: Australia, Canada, and the US had heated debates on whether to adopt a national health insurance decade following the Second World War, although it was only the initial two that did so by the 1970s.

This has continued to be the case in Canada regarding the consideration of adopting a publicly funded psychotherapy. The Mental Health Commission of Canada (MHCC) released a series of grey literature reports which looked to the United Kingdom and Australia as international examples that Canada could learn from if the country were to adopt a publicly funded psychotherapy program. Through 'learning abroad' the MHCC was able to identify how Canada could fund the program as well as potential ways it could be set up. Two strategies were to either to adopt the United Kingdom's **grants-based program** in which in Canada we could have public money allocated to hospitals, community health centers and other publicly funded health care and social service vehicles to pay providers for psychological services (Bartram, 2019; Mental Health Commission of Canada, 2017). Alternatively, there was Australia's **insurance-based model** which meant adopting a public insurance plan that would effectively allow psychological service providers to bill the government for their services (Bartram, 2019; Mental Health Commission of Canada, 2017).

(d) Policy Entrepreneurs

Similar to the general public policy literature, policy entrepreneurs are also visible within the health policy space as having had an impact on the development and evolution of health policy. However, according to Béland & Katapally (2018) they are less frequently applied to explain policy changes in the field of population health, despite the fact that the integration of policy entrepreneurs into population health frameworks and models could increase the probability of evidence-informed policy change. Oliver (2006) discusses the crucial role of leadership and strategy being central variables in determining whether and how a government responds to a pressing public health problem (217). He also notes that policy entrepreneurship can be determined by "a few identifiable individuals, a loosely set of groups, a formal coalition, or governmental body (218)." Macnaughton et al. (2013) also describe how the role and impact of

Senator Michael Kirby – who authored the first national report in 2006 that called on all of Canada to reform mental healthcare and addictions services within the country – had all the characteristics of a policy entrepreneur. In short, the entrepreneur literature in the mental health policy space demonstrates both impact and lack thereof as well as a lack of overall consideration as an explanatory factor in resulting policy change.

IV. THE JURISDICTION CASE - Canadian Mental Health Policy

The story and history of mental health in Canada has been largely one of exclusion, evasion and neglect (Bartram & Lurie, 2017). Mental health has been considered "too stigmatized, too expensive, and too jurisdictionally thorny to be appropriately prioritized" (Bartram, 2016). In 1957, the federal government's decision to exclude mental health hospitals from public health insurance opened a significant gap that has not closed. Thus, historically, mental health policy in Canada has developed in a highly political, complex and contested environment (Bartram, 2016).

Canada as a nation is an interesting jurisdiction to study mental health policy as it was a "late bloomer" as compared to other jurisdictions, and their fellow Westminster parliamentary system colleagues. The United Kingdom and Australia had each adopted a national mental health strategy or plan two to three decades ago, in 1999 and 1992 respectively. Canada remained a laggard, having not done so until 2012, and only after the 2006 Senate Report where Senator Kirby highlighted the need for greater attention at the federal level towards mental healthcare. At that time, Canada was the only G8 country without a fully formed and complete national level mental health strategy. As a result, it is interesting to further investigate two provinces in Canada who have had varying degree of success in achieving mental health reform within their respective jurisdictions.

Furthermore, it is important to note that a large majority of the research and work that has been done within the Canadian mental health policy space has focused on Canada as a whole or single provincial case studies, most notably Ontario. As a result, there is a significant gap in understanding mental health policy change within Canadian provinces and territories on a comparative basis. This is important to note as the delivery of healthcare services, including

mental health, remains a primary provincial and territorial responsibility. Thus, exploring similarities and differences across Canadian provinces and territories can serve as a benefit for future policymakers and researchers alike in understanding the complexities associated with and driving mental health policy change within the country and offers greater opportunities for learning 'within' as opposed to only 'abroad.'

Justification for Case Selection

Ontario and British Columbia are ideal comparisons as both share similarities within their health systems. According to the Conference Board of Canada, British Columbia and Ontario both ranked as the top provinces for overall health outcomes, largely because their residents lead healthier lifestyles in comparison to other Canadian provinces (The Conference Board of Canada, n.d.). Additionally, both have provincially funded healthcare coverage through the Ontario Health Insurance Program (OHIP) and the Medical Services Plan (MSP), respectively, and due to the early decisions made from the federal government to exclude mental health hospitals from public insurance had the expectations to not adopt a publicly funded mental healthcare program. However, a key difference between the two provinces, despite both similarly experiencing barriers by the dominant medical model, is that on April 1, 2015, the province of Ontario completed its almost decade long process of regulating the profession of psychotherapy (which is also the same day that the College of Registered Psychotherapists of Ontario officially opened), whereas in the case of BC, the profession remains *unregulated.* Shortly thereafter, Ontario became the first province in Canada to adopt a more fulsome public psychotherapy program, whereas British Columbia, who had the expected conditions to do so, did not. This difference represents a potential explanatory factor, either as an ideational or institutional explanation, between the two jurisdictions that warrants investigation in terms of its potential for impact on the policy outcome differences on both timing and scope for policy change.

While I provide a brief historical overview of the deinstitutionalization period of mental health change which occurred in the 1960s for background context, my research primarily examines the time period of the mid-2000s and onwards and following the release of the Kirby

Report, *Out of the Shadows At Last,* the first comprehensive examination of mental health concerns in Canadian history. This led to the development of the Mental Health Commission of Canada in 2007, and the adoption of Canada's first ever Mental Health Strategy in 2012. More specific to my case studies, British Columbia adopted its low-intensity mental health program Bounce Back in 2008 following the release of the Kirby Report, and Ontario's path towards the adoption of a more intensive and universally available publicly funded psychotherapy program began in 2011.

V. DATA, INFORMATION AND EVIDENCE GATHERING

As part of the process tracing case study approach, this research project uses two qualitative primary research sources: documentary analyses and elite interviews which contain both advantages and disadvantages. Qualitative research allows for the in-depth exploration and understanding to allow for making plausible interpretations of policymaking processes by analyzing data that is narrative in nature, identifying common themes and perspectives, as well as differences (Hadjistavropoulos & Smythe, 2001). As Mantheim et al. (2002) states, while "quantitative researchers are usually able to employ some well-established rules of analysis in deciding what is evidence for or against their theory…[through] tools such as measures of statistical significance and statistical tests of validity, as well as formal logic…qualitative researchers generally lack this type of commonly agreed to and 'objective tool.' Rather, they must rely on their ability to present a clear description, offer a convincing analysis, and make a strong argument for their interpretation to establish the value of their conclusion (317)."

Documentary analyses is the process of reviewing and/or evaluating documents both printed and electronic in a methodical manner. These include published academic articles, grey literature, public service announcements, and news articles etc. There are benefits to conducting a documentary analysis as it is both an efficient and reliable form of gathering and analyzing data. Documents are stable and 'non-reactive' in that they can be read and reviewed multiple times and remain unchanged by the researcher's influence or research process (Bowen, 2009: 31). However, the disadvantages of documentary analysis lie in not so much the technique, but rather, the notion that they are not created with 'a research agenda in mind' and

thus, often require investigative skills. Additionally, documents may not be perfectly positioned to provide all of the necessary information which are required to answer your set research question(s). Some may provide a small amount of useful information, whereas others may provide none at all.

Documentary Analyses

My dissertation is largely dependent on documentary analyses such as government documents from the Government of British Columbia and Ontario and relevant stakeholders, such as the Mental Health Commission of Canada (MHCC), Canadian Mental Health Association (CMHA), the Centre for Addiction and Mental Health (CAMH), as well as those in relation to the origins of the OSP program (i.e., four hospitals from the pilot project) and Bounce Back. Given that my research looks at mental health policy change which took place in the early 2000s and it has been less than 30 years since these events occurred, archival records were not available. Thus, to overcome this, I relied heavily on grey literature such as policy reports on mental health policy in Ontario and British Columbia, government, and stakeholder responses to these reports, as well as media coverage and responses found online. I have been able to gain sufficient information from relevant stakeholders, hansard, media coverage, and documents provided that mental health has historically been a heavily debated, stigmatized, and undervalued topic within the realm of healthcare. The grey literature was used to uncover the thoughts and justifications on the adoption and the delivery of a publicly-funded psychotherapy program from relevant stakeholders within the realm of mental health such as physicians, allied mental health professionals, policymakers, and healthcare leaders.

Sampling and Elite Interviews

I conducted over 30 semi-structured elite interviews in Ontario and British Columbia from March 2022-July 2023. These interviews were useful with triangulating my methods, as they helped corroborate my initial findings, as well as 'the incorporation of additional information' to what a single data source may have been able to provide (Davies, 2001). Triangulation is particularly important in research that involves elite interviews which intend to obtain a fuller

understanding of the situation being investigated, particularly when researching areas that are politically sensitive (Davies, 2001). I was aware that obtaining elite interviews would be difficult for various reasons, namely due to availability and time constraints. Thus, I took the recommendations of Kezar (2008) to ensure that I 'conducted extensive analysis of the documents and background work before conducting interviews.' Similarly, Harvey (2011) also recommends that researchers should 'show that they have done their homework' when interviewing elites provided that they are busy individuals with time constraints. Thus, to overcome this, I took the time to study the history of the elites I planned on interviewing and worked in preparation for the interviews (Stephens, 2007).

My interviews were semi-structured, thus, the nature of the questions were open-ended, allowed for more elaborative discussion with the interviewee rather than simply responding to straightforward "yes" or "no" questions. My primary goal of the interviews was to enable policymakers and healthcare professionals to delve deeper into their individual trajectories, professional experience, perceptions of mental healthcare and strategies in which the provincial government undertook to make changes in mental health policy. Provided that the role of policy makers and healthcare professionals are different, it was difficult to develop a standardized set of interview questions, thus, I went into the interviews with a list of general questions which asked about their role, motives and ideas surrounding mental health reform in Ontario and/or British Columbia. Prior to conducting my interviews, I received approval for my interviews from the McMaster Research Ethics board. Lastly, I am aware of the limitations of interviews due to 'faulty memories, self-serving statements, misrepresentation, or elusiveness,' (Martin, 2013; Todd, 2014), but this was mitigated by not solely relying on interviews to obtain primary data, as well as conducting thorough documentary analyses beforehand.

Prior to conducting the interviews, I used purposive sampling by preparing a list of individual stakeholders on an Excel document from the government, non-profit organizations, and mental health hospitals within Ontario and British Columbia. In terms of getting access to these individuals, I primarily identified them through searching on social media platforms such as Twitter and LinkedIn – which I also utilized to reach out to them. In the case an email and phone number were available (often through RocketReach), I would subsequently reach out to

them through these platforms as well. In some cases, I was able to receive referrals and e-introductions (as my interviews took place during a pandemic and were virtual), through my earlier interviewees and personal websites. Elite interviews were considered the most appropriate for my research question and theoretical framework provided I had no access to the archives – as the events I am exploring in the context of a province-wide, publicly-funded psychotherapy program occurred less than 30 years ago and would not be available, and because elite interviews allowed me get an insider's look as to why and how these events unfolded during the time they did. They also allowed me to triangulate my findings through documentary analyses of various published non-governmental and governmental reports, hansards, governmental announcements, and news articles.

For recruitment, I used a combination of both purposive and snowball sampling. Purposive sampling refers to a recruitment technique in which the researcher relies on his or her own judgement to select or reach out to specific researchers. Prior to conducting interviewees, I had a Master list on an Excel document of potential interviewees in both Ontario and BC that I wanted to interview. These individuals were selected based on their role – usually leadership positions within relevant mental health organizations such as the Canadian Mental Health Association (CMHA) or the government such as the Ministry of Health and Mental Health and Addictions, in addition to mental healthcare providers such as psychiatrists, psychologists and social workers.

Snowball sampling is a recruitment technique in which research participants are asked to assist researchers in identifying other potential subjects. This is more common in the case where the research topic or matter is not sensitive or personal, thus, it is acceptable for subjects to provide researchers with names and contact information for people who may be interested in participating in the interview.

Given that I was conducting elite interviews to understand the narrative of how two mental health programs in BC and Ontario were adopted, I saw that there would be no risk to the subjects. All of the interviews were conducted over Zoom and with the consent of all interviewees, and all of the interviews were recorded for transcription purposes. The names of interviewees who are explicitly referenced provided their consent to do so. Otherwise, they are

cited in the paper with a code of either BC or ON, depending on their jurisdiction, and a number. A strong majority of my interviewees in both provinces were comfortable with having their names cited, although a couple of my interviewees in BC and ON did ask to remain anonymous due to reasons ranging from still being involved with the said organization or the government. Obtaining interviews in Ontario was particularly easy due to location – as I reside in Ontario, and I was much more familiar with the Ontario landscape making it easy in terms of knowing who to contact, whereas, in the case of BC, it was slightly a bit more challenging. This, in part, may have also been because my interviews took place during a global pandemic. Thus, I could not physically conduct these interviews in person, thus, particularly in the case of BC, snowball sampling served as particularly useful in gaining access to relevant interviewees.

Data Analysis

I asked each of my interviewees for permission to also audio-record our conversations prior to the interview taking place. Due to my fieldwork occurring during the COVID-19 pandemic, I utilized Zoom to conduct all of my interviews which provides a free transcription service for all recordings that are saved on the Cloud. After the interviews ended, I would then listen back to the interviews which more often than not revealed valuable information that "I had missed out" on during the time the interview took place. I then performed a thematic analysis by hand coding for common themes and phrases that my interviewees from Ontario and BC said, and looked for similarities but more importantly, differences to explain conditions that allowed for the adoption of a province wide program in one province, but not the other.

Limitations

Provided a large contribution of this dissertation to the existing literature on mental health policy is narrative in nature, there is a possibility that the key actors I identify may not be "all" the key players who played a role in the events that unfolded namely due to the limited time and resources I had access to. The interviews took place during a global pandemic and were conducted via Zoom and although there were some informants I reached out to, I either could not get in touch with them, or they were not willing to be interviewed. Thus, this narrative is

entirely based on all the publicly available data, resources, and interviewees I could access at the time.

Terms, Concepts and Definitions

(a) Ideas

Defining and tracing ideas is inherently complicated and can involve either relatively simple and straightforward approaches that focus solely on the presence of ideas or engage in more complicated investigations involving power and evolution (Campbell, 2002; Parsons, 2016). For the purposes of understanding the presence of changing ideas and the evolving understandings of mental illness and the appropriate forms and types of treatments and treatment provides in the broader policy space, I define **ideas** as those that articulate the "beliefs held by individuals or adopted by institutions that influence their actions and attitudes (Beland & Cox, 2011)."

I know there is evidence of ideas around mental health policy changing when I perform documentary analyses through various forms of literature such as: news articles, policy documents, and press releases from policy entrepreneurs (i.e. healthcare leaders) as well as conducting interviews which demonstrate what has been said regarding mental health policy in the earlier years such as the 1960s versus now. Some of the evidence of ideas will be more explicit through mention of words referring to "mental health reform" or governmental announcements on new mental health programs, while others will be more subtle and inferred from the overall context and discussions. As I am interested in what ideas were used to support or refute policy changes, the mere presence of the ideas alone is sufficient for this purpose, without needing to interrogate the underlying beliefs or commitment of the proponents of them.

In addition, I focus on the presence (or absence) of three different levels of intersecting ideas in the mental health policy space. I look for expressions of a changing focus on:

a. types of illness or illness priorities,
b. the types and availability of treatments for mental illness, and
c. the range and qualifications of appropriate treatment providers in the mental health policy space.

On the types of illness or illness priorities, I look for shifting ideas and expressions around the types and priorities of mental illnesses that are the focus of government policy efforts. While it can be difficult to differentiate mental illnesses on the basis of types, I focus on two specific aspects – severity of illness and/or substance and addictions related illnesses. On types of treatment, I draw distinctions between different types of treatments – pharmaceutical versus talk therapy and different forms of talk-therapy. In terms of treatment providers, I considered medical (physicians) versus non-medical providers of care as well as psychologists versus non-psychologists in the latter category.

(b) Policy Legacies

I define **policy legacies** as past decisions that determine or at least have an impact on future policy choices and that make future policy change difficult (Campbell, 2002). I know I have found evidence of legacies in healthcare when there is reference to the early conditions and decisions set by the Canada Health Act as well as reference to the medical model. I also know that I have found inferential evidence of policy legacies when, despite substantial evidence and learning having occurred whether through new published literature or policy debates, that the ideas from decisions made earlier on, continue to persist overtime and result in no policy change. These aspects will also be evident through the assertion of either exclusive or predominant authority or expertise over an area of treatment that is reflected in the exercise of jurisdiction by professional based regulatory authorities.

(c) Policy Learning

I define **policy learning** as increased understanding of a policy topic or issue that occurs when policymakers compare a set of policy problems to others, either locally or internationally. I also understand that that learning for jurisdictions can occur in two ways: internally, within their own jurisdiction (through policy successes and failures) and externally, outside of their own.

For internal learning, I know that there is evidence of learning that occurred if the documentation implicitly refers to or my interviewees explicitly mention policy issues that have been attempted to be solved and were either a policy success or failure. For external learning, I

know that I have found evidence of policy learning when I come across government policy documents that are labelled as "jurisdictional/environmental scans" or "international examples" or "best practices" and which examine the policy initiatives or outcomes of jurisdictions outside of their own. I also know when individuals such as policymakers mention or propose what other jurisdictions besides their own are doing to address a similar mental health policy issue as evidence that some type of learning may have taken place, even if it was not ultimately adopted as the preferred policy choice.

(d) Policy Entrepreneurs

I define **policy entrepreneurs** as actors who engage in collaborative efforts to advance policy change. They "could be in or out of government, in elected or appointed positions, in interest groups or research organizations" (Kingdon, 1984). In keeping with the difficulties identified in the literature on entrepreneurs, my primary means of identifying policy entrepreneurs and differentiating them from policy actors will be through whether an individual or group or organization is identified as such, either through the documentary analysis and/or through interviewee responses (Arnold et al. 2023). Additional indicators of entrepreneurship may also include:

a. An ambitious individual who works inside or outside of government that seeks to achieve policy change, even if it challenges the current status quo (Mintrom, 2015);
b. Is strategic in taking advantage of the window of opportunity and problem-framing;
c. Has credibility through a combination of experience and/or education working in the bureaucracy or their respective field that seeks policy change;
d. And is a team player where they can promote their ideas through their networks, organizations, and the bureaucracy. Thus, I also define policy entrepreneurs as 'idea carriers.'

While the literature demonstrates that policy entrepreneurs can be individuals who have the above characteristics, one gap in the literature is that there is a lack of consideration of what

would happen in the case of not being successful in achieving policy change. In this case, I would still classify them as a policy entrepreneur as they have been identified as one by other policy actors in the mental health field or the documents confirm such a role for them.

Summary

This chapter aimed to set out the methodological approach to answer the dissertation's research question of "Under what conditions do jurisdictions achieve different levels or distinct scopes of policy change in general and, particularly in relation to the health and mental health policy spaces, and at different speeds or times?" Utilizing a qualitative analysis methodology, process tracing allowed for me to explore how or whether a potential cause or causes influenced a set of policy changes.

My research was carried out in two stages: (1) conducting documentary analyses followed by; (2) semi-structured elite interviews to triangulate my findings. Both qualitative methods helped me gain a deeper understanding of the mental health policy space in both provinces, Ontario and British Columbia, and helped uncover previously unknown relations between factors. While the documentary analysis uncovered mental health reforms that took place overtime through changing government and leadership and political climates and conditions, the interviews allowed for me as researcher to collect data on the thoughts, feelings, and beliefs and ideas of key actors within the mental health space, to gain a broader understand of how this drove or prevented policy change from occurring.

CHAPTER 4: BRITISH COLUMBIA'S CASE FOR NOT ADOPTING A PUBLICLY FUNDED PSYCHOTHERAPY PROGRAM

In response to the 2006 Senate report which called for community-based mental health reform, BC was one of the first provinces in Canada to respond to the momentum (Farmanara et al., 2016b). In 2007, the province of BC introduced a CBT-based mental health program called *Bounce Back*. Since then, the program has launched across BC and other Canadian provinces.

Bounce Back is described as a free skills-building program run by the Canadian Mental Health Association (CMHA). It is designed to help adults and youth aged 13 and over (previously was 15+ when it first was launched) to manage mild to moderate depression, anxiety, stress or worries. It has also been advertised as a program that was designed to help family physicians meet the demands of their patients while lessening the demand on the healthcare system (Lau & Davis, 2019). Given that they are the first point-of-contact between patients and the healthcare system, it is quite common for individuals to discuss their mental health concerns with their family physician. However, many family physicians reported feeling both overwhelmed and unprepared to either provide or direct their patients to the appropriate mental health resources. As a result, the Bounce Back program was considered a resource that could bridge that gap.

As a mental health program, Bounce Back can be delivered either online or over the phone with a Bounce Back "coach" who helps direct individuals to the tools that will support them on their path to mental wellness. The Bounce Back team consists of a combination of healthcare professionals from different backgrounds such as clinical psychologists, administrative staff and 60+ coaches who provide telephone-based support in over 15 different languages. Bounce Back coaches are not necessarily clinicians – although they might have a mental health background such as social work – and are extensively trained by a registered clinical psychologist in order to be able to deliver the Bounce Back services (Bounce Back Ontario, n.d.).

While the program can be accessed either through referral from a primary care provider (family physician, psychiatrist, or nurse practitioner) or through self-referral (provided that the

individual is connected to a primary care provider), there is a requirement to be linked to a family physician or other primary care provider. Other healthcare professionals, such as social workers, case managers, or school counsellors, may assist their clients in filling out the form and submitting it on their behalf, but will still have to include the primary care provider's information for the individual as well. The family physician or primary care provider piece is important due to the origins of Bounce Back being a program that was introduced in the province to alleviate the burden of family physicians and primary care in supporting their patients with mild to moderate forms of mental health illnesses such as anxiety and depression, provided they are the first point of contact for all healthcare services.

This chapter delves into the details of BC's story – both successful and unsuccessful – of mental health reform. Presented in in chronological order, the chapter explores the different eras that the mental health policy space in the province experienced:

1. The deinstitutionalization period of the 1970s and the downsizing of Riverview Hospital and the singular focus on more severe forms of mental illness,
2. Overall healthcare system and primary care reform which set the stage for future decisions on the delivery of mental healthcare within the province,
3. The shift in priorities towards a focus on preventive mental healthcare as well as depression and anxiety, and
4. The bureaucratic resistance towards a province-wide publicly funded psychotherapy program and a re-shift in priorities to severe mental health issues as well as addiction and the opioid crisis.

The story in BC is one that is full of ups and downs. Starting as an early adopter and a leader in mental health through the creation of Bounce Back (as a small and quick policy choice), the province ultimately decided to not adopt a fully publicly funded and large-scale psychotherapy program, despite mounting evidence from international leaders such as the UK and Australia that it could be beneficial in expanding access to mental health services to treat common disorders such as anxiety and depression. This outcome is explained by the roles and ideas of the actors that pushed for mental health policy reform and change and that were not as visible in the province. In particular, there was:

a. Shifts in mental health policy priorities, from less severe or serious mental health illnesses to mild to moderate mental illnesses such as depression and anxiety;
b. Contestation over the appropriate forms of mental health treatment and services and, more importantly, the relevant and appropriate treatment providers, and that continued to privilege a more medical based focus on mental health treatments; and
c. A lack of advocacy in favour of an expanded scope of mental health treatment, including status quo advocacy by a key policy actor in the BC mental health policy space.

I. THE DEINSTITUTIONALIZATION ERA WITH A FOCUS ON SEVERE MENTAL HEALTH ILLNESSES

Background

Similar to the rest of Canada, BC's history of attempting to modernize its mental healthcare was marked by grand announcements and slow, incremental progress. Opened in 1872, the *Victoria Asylum* was the only mental health treatment facility in the province of BC at the time. However, it quickly became overcrowded and proved to be inadequate in meeting the demands and providing the necessary mental health services. Thus, the decision to move the hospital to New Westminister – which was later renamed as the *Provincial Hospital for the Insane* in 1897 (Eugenics Archive, 2013) – was made.

When the hospital became overpopulated in 1913, a new institution opened in Coquitlam, British Columbia called *Essondale* (which was later renamed as Riverview Hospital). The institution was named after Provincial Secretary, Dr. Henry Esson Young who had advocated for the creation of the hospital. On April 1, 1913, a permanent provincial mental health hospital, administered by Dr. Henry Esson Young was opened, Riverview Hospital, and housed about 4630 patients by 1951 (Ombusdsman: Province of BC, 1994). Riverview Hospital was considered the model of psychiatric healthcare at the time and considered one of the most progressive asylums in North America, which later earned them funding from the Rockefeller Foundation, a private American philanthropic foundation for medical research and the arts (CBC, 2014). Underlying the development of this mental health policy system were two key and core ideas. First, mental health policy concerns and diagnoses were focused on the most severe forms of

mental illness and particularly those where the afflicted may be perceived to pose a danger to themselves or others. Second, the appropriate form of treatment for mental illnesses was seclusion in institutionalized care and often located in remote or removed locations (Boschma, 2011).

With the rise of the human rights movement in the mental health policy sphere, the move to deinstitutionalization of psychiatric patients became more widespread in Canada and similarly, in BC. As exposure on the treatments of mental illness focused on the potential for and actual human rights abuses towards individuals with severe mental illnesses being 'shut away' and treated inhumanely in asylums garnered sympathy and attention, society became more supportive of the idea of community-based mental health treatment. The new treatment idea was that rather than isolating these individuals from society within an institution, they would be better off instead by receiving treatment within a community-based setting and with the goal of eventually being reintegrated back into society. While Riverview was 'informally' downsized from over 4000 beds in the early 1960s during the broader deinstitutionalization movement in the mental health care field and along with the rest of Canada, the 1970s marked the first real initial foray by the BC government in putting the policy into movement towards deinstitutionalization and highlights the beginning of the shift in the ideas associated with defining mental illness and of appropriateness of mental health care (Ronquillo, 2009). While this movement towards the idea of community-based treatment progressed throughout the decade, the BC government undertook a detailed evaluation of its progress and the overall state of mental health approaches and services in the province in 1979.

By the end of 1980, and due to both the trend towards de-institutionalization and the increasing shift to pharmaceutical treatments and the corresponding decline of in-patient needs, part of Riverview Hospital had closed entirely as the government continued to shift more patients into regional care. At the core of this policy choice, despite conflicting opinions from the public and healthcare leaders alike on whether keeping River Hospital open was the right decision, one thing that was widely agreed upon was that the Government of BC had failed to invest sufficient funding in community resources to ensure that the transition to community-based mental healthcare treatment was sustainable. In 1987, after a series of multi-year

consultations, the Government of BC officially released their first mental health plan that discussed plans to replace *Riverview Hospital* and chart a path forward in the mental health policy space (BC Ministry of Health, 1987; Legislative Library of BC, 2008). The BC government created the 1987 draft plan to act as a guide in replacing Riverview Hospital with the shift to community-based resources and longer-term in-patient services across the province (Government of BC, 1987).

Despite the shifting attention on treatment ideas in the mental health policy space during this period towards deinstitutionalization and community-based treatment services, the focus on the other elements of mental health service delivery remained relatively the same – a focus on severe forms or types of illness and with a corresponding consideration of appropriate treatment providers as falling within the medical community, and psychiatrists in particular.

The New Democrat Party (NDP)

i. Mike Harcourt (1991-1996)

The first half of the near decade rule under the NDP government was marked by unclear and potentially contradictory approaches towards mental healthcare in the province. For example, in February 1990, the Mental Health Initiative was announced by former Premier Vander Zalm's Social Credit government (Legislative Library of BC, 1991). This existing initiative was the province's commitment for treatment to "shift away from historical institutional care to a decentralized, regionally integrated mental health system" (Government of BC, 1998: 8). However, it also included capital funding, extended over a 10-year period, to replace Riverview Hospital with smaller, more specialized regional facilities (Public Safety Canada, 2007: 26). This recommitment towards institutionalized care ran counter to both the policy directions and understandings of mental health treatment in the 1980s and from subsequent policy changes moving forward. This lack of coherence was reflected in 1991, with the BC Royal Commission on Health Care and Costs noting that the shift away from institutionalized treatment for mental illness "was not part of a comprehensive policy and that the mentally ill were generally moved into communities which were unable or unprepared to provide them with adequate support"

and called on the BC government to create "a coherent policy" with respect to treatment of mental illnesses (British Columbia Royal Commission of Health Care and Costs, 1991).

Roughly two years later, the government's increased engagement in the space remained relatively inconsistent. In 1994, the Auditor General published a value-for-money audit on the transfer of patients from Riverview Hospital as well as on other psychiatric services in the province. The Auditor's report concluded that in the short-term, starting in 1992, the transfer of patients from Riverview was not "adequately planned, implemented, and later evaluated (Auditor General BC, 1994)." The auditor also noted that the Ministry of Health did not "yet have a well-documented, comprehensive long-term plan on which shared an understanding of expectations concerning the replacement of Riverview Hospital and related patient and funding transfers can be based, or against which progress can be evaluated (Auditor General BC, 1994)."

This was a transitional period for the province where changing ideas surrounding mental health and treatment and the delivery of mental healthcare services was transitioning from psychiatric institutions to community-based mental health care services. However, the focus of mental illness was still largely on severe mental illnesses, rather than mild to moderate illnesses, such as anxiety and depression. Additionally, rather than a wider array of treatment options being available such as psychotherapy, treatment was primarily based on prescribing medication. This seemingly inchoate, and possibly paradoxical, approach to mental health treatments was also reflected in the financial challenges associated with the policy space and across most governments in Canada (Goering et al, 2000). Between 1994-1995 the operating costs of BC psychiatric hospitals and psychiatric units in hospitals totaled 424M (Sealy & Whitehead, 2004). By 1998-1999, this cost had dropped to 234M, reflecting the changing understanding of mental health treatments and with a shift away from institutional care and to community-based mental health delivery. However, a comparison of expenditures for community psychiatric services between 1994-95 and 1998-99 demonstrated a decrease from 208M dollars to 200M (Sealy & Whitehead, 2004). Despite a 200M reduction in spending towards psychiatric institutions, the funding for community care also decreased as well (Sealy & Whitehead, 2004). These funding shortfalls led to a lack of support for transferred psychiatric patients. It also, simultaneously, reflected the continuing focus and prioritization in the mental

health policy sphere towards the delivery of treatment to severe or serious mental health illnesses (Goering et al., 2000). In short, the understanding of and how to treat mental illness in the province remained in flux throughout the first half of NDP rule and with a corresponding effect on policy priorities and commitments, while the ideas associated with the understanding of mental illness continued its focus on severe mental illnesses and appropriate care to be that which was inherently medical and provided by psychiatrists.

ii. Glen Clark (1996-1999)

Following the resignation of Premier Harcourt due to a politically damaging scandal over party financing, the somewhat indeterminate path taken initially by the NDP government began to take greater shape in its approach to mental health policy following the new leadership offered under Premier Glen Clark. This is reflected in 1998, when the government announced that it wanted to develop a clearer plan to update and build upon the Mental Health Initiative that had been introduced in 1990. The Government of BC released a new seven-year mental health plan, *Revitalizing and Rebalancing British Columbia's Mental Healthcare System*, that proclaimed their commitment to enhancing mental healthcare throughout the province and came with annual funding of $125M (Government of British Columbia, 1998). This plan drew attention to the 1990 Mental Health Initiative and highlighted the continuing focus on severe mental health issues as the primary basis for the organization of treatments in the mental health policy space. The new plan noted that people with severe or persistent mental illnesses (SPMI), such as schizophrenia and major depression, were not being appropriately served within the province. Thus, it renewed a key goal of the 1990 plan to work towards generating a comprehensive, integrated mental healthcare service that placed focus on community-based care and treatment, additional staff, increased advocacy, and more rehabilitation programs (Berland, 2003).

Coinciding with these renewed community-based treatments, which continued to place focus on severe mental illnesses, another important development within the province was the establishment of the position of *Mental Health Advocate.* This position, the first of its kind in Canada, was initially staffed by Dr. Nancy Hall in August 1998, in order to help monitor systemic

problems within the province's mental healthcare system. The advocate's role was to "provide a single information and referral source for advocacy resources (Ministry of Health, 1998)." This development reflected a potential change in the understanding of those individuals who might have some say over appropriateness of treatment by opening up and providing for more patient- and patient family-based inputs into treatment options and a potential future for alternate treatment models, particularly community-based care. This extensive and ambitious plan made mental health providers, their families, and consumers alike quite happy.

iii. Ujjal Dosanjh (2000-2001)

Similar to his predecessor, Premier Clark was also forced to resign due to allegations of financial impropriety, albeit this time on his own personal account. The ensuing leadership contest resulted in the selection of the Ujjal Dosanjh as Premier of the deeply unpopular NDP government that had been in power throughout the decade. Against this backdrop, the mental health treatment policy space continued to evolve in more community focused directions. On February 17, 2000, a week before Premier Dosanjh's appointment, BC Health Minister Penny Priddy, announced the establishment of a new Mental Health Advisory Council. Priddy justified its creation on the grounds that:

> "Involving people who use or work in the mental health system, and those who have family members with mental illness, adds valuable insight so that changes in the mental health services will be relevant to people in communities where they live (Government of BC, 2000)."

The Council, made up of 15 mental health service consumers, family members of those living with mental health concerns, and medical and non-medical service providers, would be responsible for advising the Health Minister on the progress of the mental health reform within the province. This marked a logical but notable extension of the relevant policy actors in the mental health policy sphere to include not only medical providers of mental health care, but also a broader range of community based-service providers, family members and those with lived-experience. Coinciding with this development was the recognition within the province of the need to consider mental health and mental health treatments more broadly than they had

historically and that mental health care might also require non-medical supports through things like housing and rehabilitation.[6]

iv. Summary of Mental Health Changes under the NDP

Overall, while some progressive changes, such as the introduction of the role of the Mental Health Advocate as well as the Mental Health Advisory Council, were introduced during the tenure of the NDP government, the overall changes regarding the key focus of mental health policy and the coinciding treatment options and programs and access to alternate treatment providers were minimal. In terms of ideas about the mental health policy space, the following elements remained particularly important:

i. The understanding of mental illness continued to be overly concerned with severe forms of mental illness.

ii. Treatment of mental illnesses was a bit mixed, with there being inconsistent approaches in the early part of the NDP government's mandate, as evidenced by the adoption of the preceding Social Credit government's emphasis on community-based treatments while also re-prioritizing institutionalized care. However, by the end of its decade in power, the NDP government had more fully embraced de-institutionalization and the community-based treatment model as a path forward, albeit without sufficient resources to fully enable the policy shift.

iii. In terms of treatment service providers, the publicly funded and available system continued to be driven by medical doctors. Towards the end of the decade, there was some acknowledgement of the potential for a broader range of service providers or at least that they may play some role in advocating within the system, but the system was still organized around treatment provided by psychiatrists and family physicians.

[6] This broadened policy understanding and the need for more than just medical treatment and care is also reflected in 2001, when the Advisory Committee reported to the Campbell Liberal government on the government's progress on the 1998 *Revitalizing and Rebalancing* Plan.

II. THE HEALTH CARE AND PRIMARY CARE REFORM PERIOD

The Liberal Party

i. Gordon Campbell (2001-2011)

When Gordon Campbell came into power as leader of the centre-right Liberal party in 2001, his government's priorities were heavily focused on reductions in the levels of taxation in the province and a corresponding need to reduce government expenditures. The mental health policy sphere was not exempt from these cost cutting pressures, including early changes such as the elimination of the position of *Mental Health Advocate* and the protected funding specifically allocated towards mental health services. Additionally, the government reduced the staff within the Adult Mental Health Division of the Ministry by 70 percent, and thereby radically altering the Ministry's policy and leadership capacity on this front.

At the same time, however, Premier Campbell also announced several new strategies related to mental health during his leadership and elevated the policy issue to a Cabinet level priority by replacing the eliminated position of Mental Health Advocate with a newly created Ministry of State for Mental Health, and appointing the first Minister to the new portfolio, Gulzar Cheema, in June 2001 (Legislative Library of BC, 2008). Despite these new announcements, the Advisory Council (from the Dosanjh era) reported that three years later, in 2001, on an evaluation of the 1998 Revitalizing and Rebalancing Plan. Their report showed that the government had still not fulfilled and was behind on many of the commitments from the 1998 Plan – including the creation of performance measures and accountability structures in mental health, the development of a comprehensive discharge planning for individuals that were or would be discharged from hospitals, the lack of adequate community-based resources and the meeting of targets for housing, clinical care, rehabilitation, and crisis services and supports.

These initial changes by the Campbell Liberal government reflect a continuing inconsistency in the approach to mental health treatments and, to a lesser extent, the expansion of the relevant policy actors in this space. Mental health illnesses continued to be focused on treatment for severe forms of mental illness. The efforts to shift treatment out of institutions and into community-based care remained a commitment, but one that had been

poorly implemented and administered and remaining focused on institutionalized patients. The expansion of the policy community to include greater levels of patient advocacy was paradoxical – the elevation of this role in the policy space was both eliminated through the cancellation of the Mental Health Advocate's office but also raised to a government priority through the creation of the new Mental Health Ministry.

Restructuring of Health Services Governance Model in BC

Change would continue to occur in the broader health policy space under the Campbell government and that would have a continuing impact on mental health service delivery in the province. On December 12, 2001, BC's Health Planning Minister Sindi Hawkins announced that the government would "introduce a simpler, more accountable structure for delivering health services (Government of BC, 2001)." Hawkins explained that "creating fewer, more accountable health authorities…[would] help minimize the duplication of administrative services that are adding confusion and costs to the healthcare delivery in the province" (Government of BC, 2001). The former BC healthcare governance model was made up of 52 health authorities and nearly 600 appointees from various health boards and health councils. This original combination of small rural community councils and large urban health boards had generated large disparities in budgets, which further exacerbated the difficulty in planning and delivery of coordinated healthcare, including mental health (Government of BC, 2001).

The new model comprised of seven health authorities (RHAs): an overall provincial health services authority, followed by five regional health authorities, and a First Nations health authority which would be responsible for providing oversight and managing fifteen health service delivery areas. Under this new revised health governance structure, the provincial health services authority was responsible for working with the five RHAs to plan and coordinate the delivery of provincial programs and specialized services as well as governing and managing the organizations that provide specialized health services throughout the province (Ministry of Health, n.d.). The five regional authorities were responsible for governing, planning, and directly delivering the healthcare services within their specific and respective geographic areas. This meant that they were responsible for:

- Identifying population health needs;
- Planning appropriate programs and services;
- Ensuring programs and services were properly funded and managed; and
- Meeting provincially mandated performance objectives.

Similarly, the First Nations Health Authority, which aimed towards improving health outcomes for First Nations peoples in British Columbia, was equally responsible for:

- Planning, managing, delivering and funding First Nations health programs and services;
- Working with BC's Ministry of Health and health authorities to address services gaps and improve health outcomes for BC First Nations; and
- To improve the quality, accessibility, delivery, effectiveness and cultural appropriateness of healthcare programs and services for First Nations peoples. (Government of BC, 2021)

The underlying rationale for this reformulation of the delivery of healthcare was to reflect the varied needs across the province. With the creation of different health authorities from within different geographic areas across BC, it was expected that there would be different ideas and priorities from each of the local health authorities that were reflective of their given and potentially different population needs. At the same time, it was also expected that this would reduce the need for overall direction and control (and perhaps accountability) from the Ministry and the provincial health authority.

However, Dr. Carole Richford, President of the BC Psychiatric Association discussed how the role of Health Authorities in BC would, in fact, lead to greater difficulty within the province in adopting a centralized, province-wide mental health program:

> "Nothing in British Columbia is centralized. It's Health Authorities – so there is the Ministry of Health and 7 Health Authorities – there is very much we'll endorse stuff, but Health Authority, you deal with it and organize it. It's a very piecemeal way that care is delivered in British Columbia depending on which Health Authority you're in. … There's a huge [variation] in the haves and have nots within the province and it's based on the Health Authorities and on top of that you have the First Nations

> Health Authority. So, the government definitely downloads it onto the Health Authorities to organize."[7]

This fragmentation and regionalization of the delivery of healthcare services in the province more broadly meant that each region would identify the priorities of and deal with mental healthcare treatment and service delivery on their own and in accordance with their own understandings of the needs and priorities within their region.

> "In BC, we have 5 Regional Health Authorities, and they basically plan and deliver their own mental health services except for tertiary services – which are provincially funded and managed. So, I think you know the maybe the government here has more of a hands-off approach in terms of other than setting strategic goals, I think it's left up to the individual regions. That's not to say that there aren't any efforts to have provincial policy direction or provincial frameworks…There's not really a need – the health authorities I think are happy with just their own jurisdiction – I don't think they look in this model of public policy direction because they are large health authorities, they are sophisticated health authorities and they kind of have it figured out. So other than big policy direction and funding, I don't think they look to the Ministry for leadership to the same extent [as Ontario]."[8]

While there remained some potential for province-wide program or policy developments and some degree of accountability, the shift to regionalized care did not necessarily resolve some of the mental healthcare priorities debates, reflecting the continued contestation of ideas around mental illness, treatments and treatment providers in the policy space.

Liza Kallstrom, formerly the Lead of Content & Implementation at the Doctors of BC, also shared:

> "The Health Authorities here in BC have much more say in how we develop programs, absolutely. But we still have a Ministry of Health that dictates provincial policy, obviously, and a separate Ministry for Mental Health and Addictions – which I won't really comment on, as most of the funding comes out of the big Ministry of Health. So, they announced special funding and are building treatment centres for substance use and recovery and treatment for mental health. There will be more beds for mental health for serious mental illnesses and that is coming from the provincial Ministry, but you have to work with the regional health authorities to see where you they need them – they have to determine that."[9]

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[7] Carole Richford (President of BC Psychiatric Association), interviewed by the author, May 31, 2022.

[8] Kimberley McEwan (former Provincial Project Manager for the CMHA BC Division Bounce Back), interviewed by the author, July 7, 2022.

[9] Liza Kallstrom (formerly Doctors of BC), Interviewed by author, July 5, 2022.

A coinciding and unexpected development and outcome of this province-wide reorganization of the health policy and service delivery administrative structures was the potential for individual actors to have unintended impacts on the overall healthcare system. Interpersonal conflicts that occurred between the different members of the respective health authorities themselves further complicated the notion of achieving consensus towards the adoption of a province-wide mental health system approach based on the need for a province-wide and funded psychotherapy program.[10] Regardless of the complicated relationships and tensions regarding the autonomy of the new health authorities, which my interviewees shed light on, there was an evident lack of entrepreneurship observed from the health authorities in pushing for a publicly funded psychotherapy program. This suggests that there was not a strong appetite for such a program in the province, and efforts surrounding treatment options for mental health were focused elsewhere.

Peter Coleridge, Former VP of Health Promotion at CAMH and BC Health Authority sheds light on the complicated relationships and existing tensions among health authorities:

> "So, how are decisions made in BC? It's not based on best practices and it's not on what the experts say or the community. It's often – not always – but often people's personal views who sit in very senior leadership roles in government and in the provincial health authorities. They're the people who make that last decision."[11]

Given these institutional arrangements (the intricacies and idiosyncrasies of these 'sophisticated health authorities', the expected 'piecemeal way of development of care,' and the strength of the well-established five regional health authorities) [12], there may have been an expectation that there would have been more mental health programs and/or greater degrees of experimentation with policy design and program delivery due, at least in part, to having a number of health authorities pursuing their own individual needs or goals. In BC, this was evidently not the case. At the same time, the overall lack of coordination by the large institutional actors may have opened up space for non-Regional Health Authority based actors

[10] Mark Lau (former Research Scientist at BC Provincial Health Services Authority & Scientific & Clinical Advisor at CMHA BC), interviewed by the author, May 27, 2022.
[11] Peter Coleridge (Former VP Health Promotion at CAMH & BC Provincial Health Authority), interviewed by the author, July 26, 2022.
[12] Carole Richford (President of BC Psychiatric Association), interviewed by the author, May 31, 2022.

to play a greater role than might have been anticipated in the design and delivery of mental health care services in the province.

Primary Care Reform

Placing Physicians at the Heart of Healthcare, including Mental Health

Coinciding with the broader institutional reforms in the health policy governance space, and like many of the other provinces across Canada, the Province of BC was also similarly undertaking primary care reform. This was led in BC by the General Practice Services Committee (GPSC) and was driven by the widespread concern in the early 2000s across Canada that primary care was on the decline. The GPSC was a joint committee made up of representatives of the BC Ministry of Health, BC Medical Association, and the Society of General Practitioners of BC, along with representatives from the province's various health authorities attending meetings as guests (M. R. Lavergne et al., 2014), and whose role was to support key activities to transform primary care in BC.

In 2002/2003, and as part of the recommended reforms, the province introduced a targeted incentive program for their primary care physicians. While BC was not alone in recognizing the problem, its solution to approaching the problem was quite unique in that BC believed that "we have to pay for what we want" (R. Lavergne & McGrail, 2016). Whereas other jurisdictions had changed the structure and organization of the delivery of their primary care towards more team-based care models, such as Ontario's Family Health Teams, and shifted away from the pure fee-for-service model, BC's solution to addressing the primary care crisis was to stick with their existing model with a slight modification. In short, the BC government continued to reinforce the idea and place physicians at the centre of the delivery of healthcare in the province and focused on coaxing individual doctors to provide greater levels of service, particularly for important primary care services identified by the government, such as chronic disease management, mental healthcare, preventive care. They also attempted to deter family physicians from offering the walk-in style practice most family physician clinics were known for. This was to be accomplished by providing additional incentive payments to physicians within the existing province's public fee-for-service model (R. Lavergne & McGrail, 2016). The province

promised physicians an additional $315 payment who accepted responsibility for the provision of comprehensive, continuous, guideline-informed care for a patient with two or more chronic conditions. In the same year of this incentive program's implementation, average billings for these incentives alone per physician exceeded $9000 (M. R. Lavergne et al., 2016).

A team-based approach to healthcare delivery, as pursued in other provinces, was rejected on the basis of two underlying rationales:

- First, that practicing family physicians in BC were not adequately trained for this model; and
- Second, that it would be difficult to apply or extend the model in regions with sparser populations and shortages in healthcare human resources.

This rejection of the team-based model ensured that healthcare delivery in the province would remain physician-focused.

In addition, and perhaps more importantly, primary care reform sought neither to introduce or support new models of care provisions, nor to support an expanded role for non-physician care providers (M. R. Lavergne et al., 2014). This decision resulted in a continued and overall focus on physicians as the primary delivery mechanism of healthcare delivery, including mental health care services. Coinciding with this, is the fact, as reported in a 2016 Globe and Mail article that due to this decision in the early 2000s, that the province now spends more than $50M a year on single incentives and an additional $100M on similar "extra" payments for speciality services such as obstetrics, mental healthcare, preventive risk assessments, and other forms of chronic disease management (R. Lavergne & McGrail, 2016). Team-based models presented an opportunity to expand access to mental healthcare services through an expansion of the range of relevant treatment providers, as there were often other non-medical allied mental health professionals readily available, such as social workers, within those approaches. The continued focus on physicians as the source of treatment services reflects the continuing strength of the ideas around legitimate treatments and legitimate treatment providers in both the broader health care space as well as in relation to mental health treatments and services.

III. THE PRIORITIZATION OF PREVENTIVE MENTAL ILLNESSES

The province's shift in focus to anxiety and depression and preventive mental health

In December 2002, the Ministry of Health's *Picture of Health* report noted both changes to the broader health system that had taken place in the early days of the Liberal government as well as several new policy plans in the health policy sphere (Ministry of Health Planning, 2002). This report was a significant in terms of its overall aim to improve the healthcare system in the province. With respect to mental health, the report stated that around 300 000 British Columbians saw their family physician each year due to depression or anxiety and made the case that increasing early intervention capacity was crucial to preventing crisis mental health situations as well as use of emergency services (Ministry of Health Planning, 2002: 51). The report also stated that there was a need to focus on best practices for treating mental health concerns such as community-based treatments. Thus, the report proposed improving access to community-based mental health services provided it was also cost-efficient. As a result, the report shared that the BC Ministry of Health Planning had dedicated $125M for ongoing community-based services (Ministry of Health Planning, 2002: 52).

The Picture of Health report discussed two reports on their strategies on depression and anxiety, both funded by the BC Ministry of Health, which highlighted the cost of these two disorders to society as a whole and through the individual. These two reports also emphasized a need to create an overall strategy which did not just focus solely on treatment but also prevention, which suggested early ideas of the benefits of prevention and detection of depression and disorder in the province. The first report, the *Provincial Anxiety Disorder Strategy,* was released in April 2002 and had four goals (Government of British Columbia, 2002):

1. Improved awareness of anxiety as a mental illness;
2. Improved access to information and services;
3. Improved appropriateness of care; and
4. Improved outcomes for people with anxiety disorders

Shortly thereafter, the *Provincial Depression Strategy – Phase One, was* released in October 2002 and which called for (Government of BC, 2002):

1. Increased "awareness of depression as a mental illness,

2. A stepped-care approach that matches the needs to the resources available, and;
3. A chronic disease management approach, including self-management tools (Government of British Columbia, 2002)"

These two reports demonstrate a marked shift in the focus and understanding of mental health needs in the province.

Second, and in addition to the enhanced focus on these two widespread illnesses, the report also reflected potential changes in treatment and treatment provider ideational elements through its calls for improved community-based treatment options, greater access to mental health information for patients and families, higher quality treatment and the creation and access to tertiary care centres. The report also discussed child and youth health services in which they stated that the Ministry of Health Services was working closely with the Ministry of Children and Family Development to develop a child and youth mental health plan to "improve [the] transition of youth to the adult mental health service system and transfer of children and youth from hospital to community services (Government of British Columbia, 2002)."

Following this, in February 2003, the *Children and Youth Mental Health Plan (CYMH)* was released and considered the first of its kind in Canada. It was recognized for its leadership in aiming to improve mental health outcomes for children and youth (Berland, 2008). The report described a framework for changes in service delivery and a plan for resourcing and implementation over the next five years (Sealy & Whitehead, 2004). Promising an investment of $44M, which was double the annual budget for CYMH services at the time, the plan focused on four key strategies:

1. Risk reduction (formal efforts to prevent or delay onset of mental health problems in children and youth or to mitigate the impact of mental health problems);
2. Capacity-building (strengthening the positive influence of families and communities to promote and support the mental health of children and youth);
3. Treatment and support (ensuring access to continuum of timely, evidence-based, effective services to children and youth with mental health problems and their families); and

4. Performance improvement (strengthening the infrastructure to support a responsive, efficient, and accountable children and youth mental healthcare system)

Ultimately, this plan demonstrated the importance of increasing treatment capacities as well as placing emphasis on "upstream" strategies that intervened earlier in the lives of children before mental health problems developed (or worsened, rather) later down the line (BC Ministry of Children and Family Development, 2008).

In short, while the initial healthcare system and primary care reforms of the Liberal government reflected the continued strength of all three ideational aspects of the mental health policy space, the subsequent developments coinciding with these three new plans or strategies suggest tentative steps to a redefinition or alternative prioritization on types of mental illness and with a corresponding potential for recognition of the need for an expanded range of treatments and treatment providers.

Refusal to Regulate Psychotherapists and Clinical Counsellors

However, as the provincial government shifted the focus or prioritization in the mental health policy space towards less serious and more preventable and treatable mental health illnesses, the issues and ideas associated with appropriate treatments and, more importantly, the provision of associated services remained contested. A key development, or lack thereof rather, in this regard was that BC had many opportunities to learn from other jurisdictions across Canada and internationally with regard to the importance of regulating a range of health care professions in the mental health care space, namely, in this case, the regulation of clinical counsellors and psychotherapists. This was an issue during the *Utendale* Case in 2007 where the BC College of Psychologists sought to prevent Dr. Kent Utendale, a social worker with a PhD in social psychology, from claiming to practice psychotherapy or to present himself as a psychologist. In doing so, the College was attempting to protect and maintain those terms of practice as both regulated and under their jurisdiction. However, and contrary to the College's request, the Court did the opposite in holding that:

(a) As the government did not exclusively designate the practice as a protected one under the regulations, anyone can practice psychology;
(b) Similarly, there were no restrictions on the use of the term "Dr." under the Health Professions Act and therefore anyone with a PhD can use the title "Dr." to denote they hold a doctorate degree, and;
(c) The term psychotherapist suggested a degree of expertise and that therefore only those persons could use the title psychotherapist if they had the appropriate training and did not suggest that they are also psychologists

This case and the corresponding judicial decision both presented an important opportunity in British Columbia to expand the ideas surrounding the types of service providers who were qualified to provide all ranges of psychological services in the province.

However, shortly after and as a result of the judicial decision, the BC government revised the corresponding regulations to somewhat reinforce the continuing distinction between psychological treatment and service providers. In particular, the government through is regulation authority and without any substantive debate, legislated "psychologist" and "psychological associate" as protected titles and that only those persons registered with the College could use them accordingly. In contrast, counsellors and psychotherapists in BC remained (and still remain) unregulated by government authority, reflecting an ongoing battle in the province that has lasted for several decades (FACTBC, n.d.). In short, while the broader practices of psychotherapy remained open for a range of service providers, a professional distinction continued to be drawn between types of service providers and reinforced the idea that there were more appropriate forms of treatment and treatment providers than others. Nazanin Moghadami, a Registered Clinical Counsellor (RCC) stated:

> "College of Social Work and College of Psychologists are not quite supportive of counsellors being registered for various reasons so that also creates a hierarchy. Especially with psychologists there is a clear hierarchy. If you work in a team where there is a psychologist and a counsellor, it almost becomes like nurses and doctors – even though it shouldn't be. Part of it is because they [psychologists] are regulated and get more money for coverage. They cover more for psychologists, social workers and then the bottom is registered counsellors."[13]

[13] Nazanin Moghadami (Reigstered Clinical Counselor), interviewed by the author, June 9, 2022.

The restrictiveness of this distinction runs contrary to potential answers to the mental health crisis in BC. The current evidence shows that a major solution towards expanding access to psychological services involves expanding the *types* of providers who can offer those services, due, in part, to the fact that there are simply not enough psychologists and psychiatrists available to offer these services alone (Kurdyak et al., 2020). To date, clinical counsellors and psychotherapists in the province self-regulate themselves and legally, "literally anyone can call themselves a therapist and start advertising their services to British Columbians who genuinely need help with their mental and emotional health (CBC, 2020)." However, this has both practical and ideational effects, particularly in relation to perceptions and concerns surrounding quality of care. Dr. Carole Richford, President of the BC Psychiatric Association stated:

> "I do know that the Master of Social Work are quite proud of what they do and offer – and you know, good for them. But they don't have any evidence-based therapy, right? CBT is the bread and butter for psychologists. Even eye movement desensitization and reprocessing therapy (EMDR) – the MSW really rely on their engagement with others and how well they get along with others and really their clienteles and friends and another friend and another friend and also having a snazzy website. But what do they offer that is different? But I think that what we know about what psychologists' offer is that they have evidence-based treatments and MSW don't. They do know resources and the community – which…that is great and navigating the world of disability. I think if they want to make a case in BC to the Ministry of Health for funding…is what's the evidence? Can you get people better? If we invest this amount of money, show us that it's worth it and I think psychologists have that body of knowledge generally whereas I'm not sure clinical counsellors and social workers have that."[14]

A Board Member from the BC Psychological Association stated:

> "The whispers that I hear are that they are getting closer to doing that [regulating BC Counsellors] that there is uptake for that, that they are going to do it. I understand so little how the politics works in this province. It would be really difficult though– because a lot of people call themselves a counsellor. How would you even do that? That's tricky business."[15]

It also has an impact on the potential access to and availability of public versus private funding models in the delivery of mental healthcare in the province. Griggs, Chair of FACTBC, who has been advocating for the regulation of counsellors for decades, stated:

> "When you don't have a protected title, what are you supposed to put on the plan? 'We'll pay for anybody who says they're your counselor?' Well, that's not going to work (Lindsay, 2022)."

[14] Carole Richford (President of BC Psychiatric Association), interviewed by the author, May 31, 2022.

[15] Board Member (BC Psychological Association), interviewed by the author, June 7, 2022.

The continuing lack of regulation of counsellors and psychotherapists has generated skepticism towards the type of work they do, particularly regarding whether certain mental health providers use evidence-based practices. Thus, regulation would certainly provide professional benefits of legitimatizing the profession. But more importantly, it would serve as an important step towards protecting the public, maintaining public confidence, and as in any healthcare setting, ensure the upholding of professional standards for psychotherapy. The refusal to regulate a large group of mental health professionals in a province reinforced the existing 'legacy' of mental health being viewed as the 'Orphan Child" to physical healthcare and in turn, suggests ideas of providers of mental healthcare services such as psychotherapists as a group or profession that is not valued.

The emergence of the Bounce Back Program

As the salience of mild and moderate level mental health concerns increased throughout the mid-2000s and despite the ongoing battle over appropriateness of treatments and treatment providers, interest in a wider range of mental healthcare treatments and broader availability of treatment services also simultaneously increased in BC and other jurisdictions in Canada (Moroz et al., 2020). In British Columbia, this pursuit was undertaken by mental health advocates adopting a UK-inspired program entitled *Bounce Back.*

Dr. Kimberley McEwan recalled what was an out of the blue event - the Canadian Mental Health Association, British Columbia (CMHA BC) received an unexpected email from the Ministry of Health Services offering it a $6M dollar grant to establish a "community-based [mental health treatment] infrastructure" – with no other specific directions. The email, which came from the Ministry of Health Services in March, coincided with the end of the fiscal year - at a time where if governmental departments ended up with a surplus of funds that were not used up by the end of the budget year, it would simply be a loss.

> "So, this was late in March that the CEO at the time of CMHA BC Division got a call from the Ministry of Health saying: "We would like to give you $6M dollars today to establish a

> community-based CBT infrastructure" and it hadn't been any ongoing conversations at that point."[16]

Dr. McEwan further elaborated that the email provided by the government had no specific directions and no details of preferred policy directions or range of treatments or appropriate treatment providers were mentioned in the email when the $6M was offered to the branch.

Shortly after receipt of the government's email, conversations within CMHA BC began to take place around which direction they might go to fulfill their newly acquired mandate from the province: "What is a community-based CBT infrastructure? Are we going to do something that is a formal system? What exactly is this going to look like?" To figure this out, the team at CMHA BC conducted an environmental scan where they came across the work of Dr. Christopher Williams, a psychiatrist and Emeritus Professor of Psychosocial Psychiatry at the University of Glasglow and the originator of the Bounce Back program.

Dr. Williams recalled that Mridula Morgan, former Program Coordinator at CMHA BC, had reached out to him directly, and that the branch was particularly interested in discussing his CBT-inspired program that had been adopted in the UK. Williams' understanding and approach to treatment for mental health illnesses such as depression and anxiety extended beyond traditional medical model-based approaches. At the time that the nation-wide program, *Talking Therapies* (formerly known as Increasing Access to Psychological Therapies), was adopted, medication had been the dominant treatment and service paradigm in the psychological treatment fields in the UK to deal with mental illnesses, such as depression and anxiety, Talking Therapies is a stepped-care program in the UK which aims to improve access to psychotherapy for individuals with common mental health disorders such as anxiety and depression. Stepped-care is a type of system that delivers and monitors mental health treatment so that the most effective, yet least resource-intensive treatment is delivered first and may include mental health services delivered by non-medically trained individuals. For example, a client may start with self-help tools and resources such as workbooks (like the Bounce Back Program in BC) with some assistance through non-therapeutic coaching. If, as a patient works through the material, they

[16] Kimberley McEwan (former Provincial Project Manager for the CMHA BC Division Bounce Back), interviewed by the author, July 7, 2022.

require greater support, they will then "step-up" to more high-intensity treatments such as face-to-face counselling with a licensed therapist.

Talking Therapies launched in the UK after major support from Tony Blair's Labour government and evidence-based goals which produced recovery results over 50 percent (Saunders et al., 2020). The program was particularly attractive and replicated in other countries, such as Canada, due to the strong evidence that certain types of mental health treatment, such as psychotherapy, did not necessarily need to be provided by a physician or a PhD-level psychologist. Instead, it could be delegated to a range of more readily available and other mental health providers, such as occupational therapists, social workers, psychotherapists, and Masters-level psychologists etc.

In speaking to the focus within the mental health community on appropriateness of types of treatment, Dr. Williams shared that while medication remained the dominant form of treatment, there were shifting ideas among individuals seeking and providing mental healthcare services for alternative forms of non-medical treatment, such as psychotherapy:

> "I'm going to be controversial and regret being controversial but it's interesting how many psychiatrists or neurologists have been involved in developing talking therapy. But medics have withdrawn doing psychotherapy themselves partly because of time pressures and partly because I think, commissioners want medics to do medic-type things, such as diagnosis, risk assessment and medication. So, there was a problem then where we had psychotherapy being done by psychologists, nurses etc. which limited access. Medication is the main intervention – which is fine, as it can be helpful – but lots and lots of people didn't want medication and were on huge, massive waiting lists for effective psychological therapies, so I think that's the context. Waiting lists and people being distressed."[17]

The UK had taken a new direction on treatment services for depression and anxiety, including one that expanded the range of service providers in the mental health policy space. While there was a range of potential talk-therapy options and ranging in degrees of patient-treatment provider interaction intensity, CMHA BC was particularly intrigued by how easily and widely accessible the online and low-intensity mental health program Bounce Back was.

[17] Dr. Chris Williams (Creator of Bounce Back), interviewed by author, July 6, 2023.

Dr. Williams further recalled that CMHA BC was particularly interested in how easily the CBT-inspired program Bounce Back, was accessible through workbooks and DVD. Williams stated: "I think it was a combination of the trending books and the DVD at the time that interested them."[18] He recalled that they (CMHA BC) had just recently received $6M in funding and after having reached out to him, they had signed an agreement in 2005/2006 (based on his recollection) and that he had passed on a training course for treatment and service providers under the program to members of the CMHA BC team. Dr. Williams noted that CMHA BC negotiated a licensing agreement to both use and modify his materials into one that was best suited for the BC community. Over the course of several more meetings with Dr. Williams, the CMHA BC team decided that the structure and format of the program would function best as a guided self-help model in which coaches, trained by or under psychologists, would connect individuals with the necessary materials and resources.

In terms of its implementation, Dr. Mark Lau, former Scientific & Clinical Advisor for Bounce Back at CMHA, BC modified the materials provided by Dr. Williams in order to expand the range of mental health service providers by preparation to train Bounce Back coaches. Another individual who was identified as being heavily involved at the time in the consideration of Bounce Back for implementation in BC was Bev Gutray, the CEO of CMHA. BC Gutray took on a similar entrepreneurial and role of that of an ideational leader.

This non-profit organization-driven Bounce Back model by CMHA BC was viewed as particularly attractive since it did not have to be delivered by physicians or regulated healthcare professionals. Instead, it could be a delegated model which self-guided individuals seeking support for mild to moderate mental health concerns such as depression and anxiety and only requiring the assistance of a coach when needed.

> "I also imagine it is both the BC commissioning would probably fit in with the ideas of fees and capacity and large numbers of community based and reaching out to communities…and posting books out so that people wouldn't have to travel to see psychologists or psychiatrists, so this idea of doing things at home with telephone support. So, I think it's about the idea of expanding reach of mental health across communities that drove it."[19]

[18] Dr. Chris Williams (Creator of Bounce Back), interviewed by author, July 6, 2023.

[19] Dr. Chris Williams (Creator of Bounce Back), interviewed by author, July 6, 2023.

The next challenge for CMHA BC was to figure out how the program was going to be accessible for and by individuals. "Was it going to be a program where individuals accessed it on their own? Was it going to require physician referral? Were they going to connect with the primary care community? Or mental health centers?"[20] In order to address this problem, there was widespread outreach by CMHA BC to the broader medical community, and primary healthcare providers in particular, who were made aware of the Bounce Back program and that they had a role to play in connecting their patients seeking low to moderate self-guided mental health resources. CMHA BC devoted some of the resources from its initial funding to pursue this option and provide family physicians with support in referring this low-intensity program to their patients.

The launch of Bounce Back was not without struggles or tensions and demonstrates the continuing ideational contest over appropriate types and levels of treatment and the treatment and service providers. Dr. McEwan recalled that they had numerous leading clinicians, researchers, and individuals from the Ministry of Health and Doctors of BC – "quite a representative committee", as she recalled guiding the province through this new endeavour. Dr. Kimberley McEwan stated:

> "Initially, there was a lot of resistance – I'm not sure what's happening in Ontario – with increased access to psychotherapy but some of the professional psychologists were not at all in favour of this. They didn't want that delivery of CBT taken out of their hands of professionals. They didn't feel that it could be a delegated kind of function. So, there was a lot of hurdles to navigate… Even some of the people who were psychologists who were employed in different institutions – like different hospitals – they weren't keen on it because they felt that it was a professional function – and because it was telephone delivery – another component of Bounce Back which they were opposed to – we wanted to make it as widely accessible as possible. So, the whole telephone delivery or coaching, at that time was rather novel – it's obviously much more common now but so, there was a lot of objections of the delegated function and the delivery model."[21]

[20] Kimberley McEwan (former Provincial Project Manager for the CMHA BC Division Bounce Back), interviewed by the author, July 7, 2022.

[21] Kimberley McEwan (former Provincial Project Manager for the CMHA BC Division Bounce Back), interviewed by the author, July 7, 2022.

Coinciding with and around the same time that CMHA BC had been commissioned to pursue the CBT-inspired Bounce Back program, the province also continued other endeavours towards increasing access to mental health services, including CBT treatments. In March 2007, a document developed by Simon Fraser's Centre for Applied Research in Mental Health and Addictions (CARMHA), under the direction of BC Ministry of Health, called the *Cognitive Behavioural Therapy: Core Information Document*, was released. This document provided an in-depth overview of the best practices for the Government of BC to support the highest quality mental healthcare and addictions services in the province. The report highlights the continuing contestation surrounding appropriate treatments and treatment providers, wherein it stated:

> "Interest in CBT had been expressed among diverse groups in British Columbia, including policy makers, health administrators, health service providers who are non-specialists in mental health, as well as consumers and their families (Somers, 2007)."

During this timeframe, there was also quite a bit of attention in BC among the mental health academic community for increased access to alternate forms of mental health treatment beyond pharmacological intervention, including the potential for greater use of talk-based therapies, including CBT. Notably, and in particular, the Simon Fraser report also mentioned the notion of a stepped care model that included access to both low and high intensity levels of patient-treatment provider interaction and was the model that had been adopted in the UK. Furthermore, the report argued that despite the effectiveness of CBT in treating psychological concerns, it was still not being used extensively in the province. Despite the timing of the report and its conclusions, the decision to provide funding to CMHA BC and its investigation into CBT services closed off both other therapies and the more intensive based CBT models approaches. It was felt, however, that Bounce Back would still result in improved access within the province to low intensity CBT, while also meeting the provincial goal of providing family physicians with support in referring low-intensity mental healthcare resources to their patients.

The goal of the Bounce Back, which officially launched in Okanagan in June 2008, was to increase availability of CBT. Based on the work of Dr. Williams, Bounce Back offered primarily two forms of support:

1. A workbook and a self-help DVD which provided tips on mood management; and

2. A telephone-delivered service in which community-based "coaches" would offer guided self-help over the phone for individuals suffering from mild to moderate forms of depression and anxiety.

All components of Bounce Back were made available to people at no cost and available through the family physician's office in the form of a DVD and self-guided workbooks.

Despite the government's seeming focus on lower end mental illnesses and the corresponding request for CMHA BC to investigate the broader mental health crisis, public websites and forums described Bounce Back as a program that was designed "to help physicians meet the mental health needs of their patients while lessening the demand on the healthcare system" (Lau & Davis, 2019). In this regard, the original motivation for the program was portrayed as being aimed at and intended to support individuals for *chronic disease management* within primary care and who might be suffering from anxiety or depression as a consequence from other health issues (Government of British Columbia, 2010; McEwan, 2009). Chronic disease management, at the time, was a heavily discussed topic within the province. Former Consultant & Project Manager for BC Bounce Back and psychologist, Dr. Kimberley McEwan stated:

> "Their [Government of BC] big agenda item within the [BC] Ministry of Health was chronic disease management. They were putting a lot of energy into that – both the fee structure for physicians and so part of the rationale for that was that they thought if we opened it up to the public at large – the adults, the general public of adults, we would be overwhelmed with referrals and a demand – but that wasn't the case. So very quickly, after restricting it to people with chronic diseases and having them referred by their GP's we – it became complicated too because a lot of people with chronic disease are on different medications – some of them which have an effect on food and activity level and weight gain, all kinds of things. So, we very quickly moved away from that and made it open to anyone with mild to moderate depression."

Thus, the idea of the Bounce Back program intending to and treating individuals with mild to moderate forms of depression and anxiety in the broader public may have been an afterthought.

The focus on chronic disease management from the outset continued to place physicians and a medical model at the core of understandings of the mental health crisis response by the province and the provision of other mental healthcare treatment and services by other providers as an ancillary concern.

> "One of the hallmarks I think of Bounce Back is the ongoing link back to primary care. So, it's not like a hand-off, off you go, you've met the criteria. You know…there's a lot of active case management with treating physician. They hold the clinical responsibility for the participant in the program which in many ways enables greater longitudinal care around illnesses that can be ongoing, remitting, relapsing, so that's how it all started. We get a lot of physician engagement, medical officer engagement to get the word out there and really position Bounce Back in the algorithm of care that is integrated into BC's Practice Support Program which is basically a physician care algorithm – one of the toolbox options for people…I would say we're a mainstay in primary care."[22]

> "Remember in BC it was not about emergency room visits…it was about supporting family physicians and chronic disease management. Since that is how I learned and understood the program, I really pitched that [to the LHIN] in the Ontario context."[23]

> "In particular, at that time it [Bounce Back] was for their patients with chronic disease – they were the biggest drain on the finances– that particular population – and the theory was that if they could treat the depression and anxiety, they'd do a better job taking care of the chronic illness and there wouldn't be so much morbidity and wouldn't cost so much to the government."[24]

> "All the people involved were trying to shift the healthcare system away from traditional episodic, acute-care focus, in and out of or come whenever you're not feeling well, and we'll give you something (usually prescriptions or something else) and then go while the population is changing to more chronic diseases - which requires a different approach. I think this team was instrumental in trying to shift the primary healthcare system to a much more proactive plan approach so that you're looking at your whole population be that diabetes, heart failure, COPD and ultimately, mental health…but mental health came a little later. So, I think it was mostly the chronic diseases that paved the way…"[25]

What comes out of the period where Bounce Back was selected, developed and introduced into the province are three key points. First, despite evidence of best practices to the contrary, there were continuing disputes within the broader mental health community over the appropriate forms of mental health treatment and services and, more importantly, the relevant and appropriate treatment providers. Second, the adoption of Bounce Back (and its limited intensity

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[22] Jonny Morris (Ministry of Mental Health and Addictions & CEO CMHA BC), interviewed by the author, May 30, 2022.
[23] Rebecca Shields (former Executive Director CMHA Burnaby and current CEO CMHA York & South Simcoe Region), interviewed by author, April 6, 2022.
[24] Mark Lau (former Research Scientist at BC Provincial Health Services Authority & Scientific & Clinical Advisor at CMHA BC), interviewed by the author, May 27, 2022.
[25] Liza Kallstrom (Former Lead, Content & Implementation, Practice Support Program of Doctors of BC), Interviewed by author, July 5, 2022.

form of therapy) was driven almost exclusively by the efforts of CMHA and through their empowerment by the government. Third, the adoption of Bounce Back was framed and justified to the medical community as an accompaniment to physician provided primary care as opposed to a new and stand-alone program to address mental health on its own.

IV. RESISTANCE TO SCALING UP BOUNCE BACK AND THE RE-SHIFT IN MENTAL HEALTH PRIORITIES PERIOD

Similar to what was put in place in the UK, mental health advocates and leaders fought a hard fight to try to adopt a stepped-care program when the Bounce Back program was first adopted in BC. Advocates pursued the idea of scaling up the Bounce Back program from a sole low-intensity program to one that was stepped-care (having both low and high-intensity treatment programs) to emulate the UK's Talking Therapies programme. It appears that once their mandate to explore mental health solutions to the crisis in BC achieved initial success with the introduction of Bounce Back, the opportunity for CMHA – BC to continue to play an ongoing and leading policy role was blunted. Their efforts in doing so at and to the BC Ministry of Health failed as they simply could not get the more larger-scale model on their attention. This is evidence of actors in BC initially playing an entrepreneurial role but being later thwarted in attempting to achieve larger mental health reform; they simply could not get the ear or support from the government.

As Mark Lau, a psychologist who had modified the Bounce Back program as well as played a role in training Bounce Back coaches at CMHA – BC noted on the lack of engagement with the government after acceptance of the smaller Bounce Back design:

> "… we had done a cost-benefit analysis of psychotherapy vs. pharmacotherapy for treating depression and had an economic analysis – we wrote it up and presented it to the Ministry of Health at one point and didn't get any traction there even though it was going to save them money. Not as a strong argument as IAPT but ours was simply if you use psychotherapy, you were going to save some money."[26]

[26]Mark Lau (former Research Scientist at BC Provincial Health Services Authority & Scientific & Clinical Advisor at CMHA BC), interviewed by the author, May 27, 2022.

…

> "And it would've been mostly the guy (Patrick Smith) who brought me out who was lobbying at the higher levels and he was trying his best and using his best arguments that he could come up with… I mean he has probably moved on from this. He fought a good fight – and couldn't convince them."[27]

In the absence of a more fully entrenched policy advocate pushing for a larger program, the government was not prepared to push beyond its initial forays into the CBT space as anything other than an adjunct to primary care being provided alongside or supporting physicians. Further evidence of the lack of continuing engagement with CMHA – BC and other mental health advocates concerning and expansion of Bounce Back was evident in the discussion with Peter Coleridge, a former VP of Health Promotion at CAMH and the BC Provincial Health Authority:

> "It's about culture and context…in BC, if there was some resources and leadership around how do we influence public policy and understanding that the culture and context there…as described, this is the hierarchy: psychiatrists, [psychologists, social workers], well, you can't just launch in and try to impose or influence"[28]
>
> …
>
> so how are decisions made in BC? It's not based on best practices and it's not on what the experts say or the community. It's often – not always – but often people's personal views who sit in very senior leadership roles in government and in the provincial health authorities. They're the people who make that last decision."[29]

Thus, despite evidence and best practices from international examples being readily available to bureaucrats and health experts within the province, BC pursued a smaller-scale program to addressing the mental health crisis. The idea of a larger-scale program, such as the one pursued in the UK, was ultimately not pursued as policy actors restricted the possibility of the adopting a province-wide publicly funded psychotherapy program in BC, continued to frame it as an adjunct to or primarily supportive of primary medical care and concomitant contest in the range of "appropriate" therapy providers, and coupled with the fact that there were no key policy actors within the Ministry or broader government pushing for its expansion.

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[27] Ibid.

[28] Peter Coleridge (Former VP Health Promotion at CAMH & BC Provincial Health Authority), interviewed by the author, July 26, 2022.

[29] Ibid.

For example, Jonny Morris, CEO of CMHA BC stated:

> "I do think IAPT needs good scrutiny. There's a fair amount of critique of IAPT in the UK. I think they've got some pretty radical transparency around metrics, and you know, I think you do need to look closely at…I think we boast a better recovery rate – they boast a 50% recovery rate. Now, they're treating illnesses above and beyond anxiety and depression whereas we're pretty restricted on those two. We have a 70% recovery rate – but again, that's a pretty skewed sample because there's people who've done the program and do the pre and the post and there's probably unique characteristics of that population that might lend themselves well to an enhanced recovery from symptoms."[30]

Above, my interviewee, CEO from CMHA BC sheds light on their vastly different views towards the UK's golden standard nation-wide CBT program. CMHA BC argues that the Bounce Back program, despite being a lower-intensity and much more cost-effective program, produces better results than the UK's Talking Therapies program.

Continued Mental Health Initiatives

The introduction of Bounce Back coincided with the continued efforts towards de-institutionalization by the BC government. The provincial government established the Community Action Initiative (CAI) in June 2008 through a $10M grant and in efforts to strengthen the role and capacity of the community sector to address substance use and improved mental health for British Columbians. A couple months after the creation of the CAI, in October 2008, *A Review of Children and Youth Mental Health Services in BC: following implementation of the 2003 Children and Youth Mental Health Plan* (CYMH) was released (Berland, 2008). Through consultations, which took place from May to July 2008 and with various community stakeholders in other ministries, service providers, family of children and youth with mental illness, and youth clients themselves, it became clear that stakeholders strongly supported the CYMH plan and its vision, although they felt there was still a long journey ahead. Additionally, the plan also included the need to enhance the availability of evidence-based therapy for people with mild to moderate mental health disorders.

[30] Jonny Morris (CEO of CMHA BC), interviewed by the author, May 17, 2022.

The CAI became a key complement to the province's subsequent comprehensive ten-year plan to address issues associated with both mental health and substance use. The *2010 Healthy Minds, Healthy People* plan stated:

> "While medications are appropriate in some cases, non-medication therapeutic approaches can be equally successful and should be considered first (Government of British Columbia, 2010)."

The inclusion of stakeholders outside of the medical space demonstrated some continued increased interest within the province in broadening the network of policy actors involved in mental health policy discussions. This, in turn, allowed for the possibility of more community-focused solutions to the mental health policy challenges which persisted throughout the 2000s.

In terms of addressing the BC population for individuals struggling or diagnosed with mild to moderate mental health concerns, the *2010 Healthy Minds, Healthy People plan* emphasized that children, youth, and adults with mental health and/or substance use concerns with mild to moderate symptoms "could be effectively supported or treated through low-intensity community services." The plan discussed that Bounce Back increased the availability of low-intensity interventions which allowed for serving a larger pool of individuals in the province. The province further elaborated on this statement in that the goal of treating mild to moderate symptoms would be done through enhancing the role of primary care, the increased availability of evidence-based therapeutic approaches and community-based mental health and substance use services, rather than an expansion of Bounce Back. Below, I elaborate on two key points that came out of the report.

Th first key point of the plan, notably, continued to place family physicians at the forefront of healthcare delivery and with the key role in managing mental health problems within the community. This would be done through ongoing medical education and professional development of physicians to ensure they maintained and continued to enhance their skills. The province also stated that they had introduced a new training initiative, through Bounce Back, for family physicians to greatly improve the provision of primary mental healthcare, given that family physicians are the first point of contact to medical care for most BC citizens. By 2015, the province also added that they intended to have at least 60 000 British Columbians have access to primary care mental health and substance use assessment and mental healthcare plans.

The second key point of the *Healthy Minds, Healthy People* plan focused on expanding access to mental healthcare for 50 000 British Columbian by 2015 by drawing on existing low-intensity services, including Bounce Back, which offered cost-effective forms of healthcare that could be accessed directly or delivered by personnel who were not necessarily licensed mental health specialists.

Despite the introduction of Bounce Back as a small and quick policy choice and its apparent success as a treatment option for less acute mental illnesses and as a key component of the preventative mental health strategy, the idea of mental health treatment provision continued to be dominated by the existing medical model. In addition, it is evident during this period that concerns with preventative mental health care increasingly began shifting beyond anxiety and depression and incorporated concerns with substance use and abuse and addition.

ii. **Christy Clark (2011-2017)**

After the introduction and implementation of the Bounce Back program, new challenges in the mental health sphere arose that further challenged the focus on or priority of anxiety and depression as the primary concern in the mental health policy space. For example, the continued operation of the Riverview Hospital remained highly controversial and regained attention within the province in 2013. After gradually reducing its patient population over the preceding two-decade period, it officially closed its doors in July 2012. However, critics immediately called on the government to re-open the mental health facility. While the idea of taking mental health patients out of institutionalized care and providing them with community-based support remained a continuing and popular trend, there also remained an ongoing debate within the mental health policy community about more severe mental illness and high needs patients and the appropriate types and locations of treatments and services. The issue from the critics of the closure was not so much that the delivery of community-based mental healthcare was ineffective – quite the opposite, in fact. But rather, it became apparent that the issue of mental health concerns for the more severe mentally ill was also largely tied to housing and the need for other and related support services – many individuals suffering with severe forms of mental illness did not have access to readily available community-based supports, and

as a result, were left to fend for themselves. Thus, there were mixed feelings surrounding the closing and/or re-opening of BC's largest provincial psychiatric hospital that persisted in the province (CityNews Vancouver, 2020; CMHA BC, 2013; CTV News, 2023).

On the other hand, other mental health advocates, such as former CEO of CMHA BC, Bev Gutray and Dr. Marina Morrow, an academic and health policy researcher, argued that the government's decision to reject a recommendation to re-instate Riverview Hospital was indeed the correct decision. Despite the overwhelmingly large amount of public support to re-open the psychiatric hospital, Gutray and Dr. Morrow persisted that doing so would not be the compassionate solution to address the homelessness or poverty crisis as much as people thought. Instead, they viewed the correct policy solution would be to take a hard look at how those with severe mental health and substance abuse problems were treated, and how to appropriately change the government's course of action. Thus, they proposed an alternative solution: ensure affordable basics costs for living for those with disabilities and addressing the lack of affordable, safe, and supporting housing options within the province (Vancouver Sun, 2022).

Coinciding with the return of the more severe types of mental health illness issues and the corresponding treatment and services needs debate was the rise of the opioid drug crisis in British Columbia (and which manifested in a need for similar treatment and other support services as the severe mental health illnesses did) and that would further complicate the broader policy environment in the mental health policy space and present a further challenge or barrier in the expansion of Bounce Back or even a province-wide publicly funded psychotherapy program. On April 14, 2016, Dr. Perry Kendall, the provincial health officer of BC at the time declared a public health emergency under the Public Health Act due to the significant increase in drug-related overdoses and deaths within the province. It was also noted that BC was "the first province to take this kind of action in response to the current public health crisis from drug overdoses (Government of British Columbia, 2016)." There was certainly valid reason to do so, as a report from the Public Health Agency of Canada noted that as of 2016, opioid-related deaths and hospitalizations rates were the highest in the British Columbia, Alberta, Yukon, and the Northwest Territories (Public Health Agency of Canada, 2018). Other literature

demonstrated that fentanyl was first reported in BC and Alberta in 2011 and since then, the proportion of deaths involving fentanyl had rose drastically (Public Health Agency of Canada, 2018). In short, the policy window and corresponding prioritization where mental health illness concerns focused on lower end illnesses, such as anxiety and depression, was superseded by a recurrence of the debate on serious mental illnesses and the emergence of the emergent drug and addiction crisis.

The New Democratic Party (NDP)

i. John Horgan

After 16 years of Liberal leadership, John Horgan's NDP entered government in 2017. As one of its first actions in the policy space and demonstrating the reduced priority on less severe forms of mental illness, the new BC government provided $101M in funding for the construction of a new mental health and addiction treatment facility on the Riverview grounds, called Red Fish Healing Centre for Mental Health and Addictions.

Failed Window of Opportunity: No mention of a publicly funded psychotherapy program in BC

At the same time that the new NDP government brought hope for positive developments in the mental healthcare space, the brewing opioid crisis intervened to recalibrate government action and divert their attention towards more immediate public health concerns, rather than pushing for the expansion of psychotherapy services. The federal-provincial agreement for the 2017/2018 targeted federal transfer of $5B over the next ten years for mental healthcare that was first introduced by Prime Minister Justin Trudeau was reached with British Columbia in February 2017. This agreement meant that over the next 10 years, the Canadian government would provide BC with an additional $1.5B: $785.7M for better homecare and $654.7M to support mental health initiatives.

For the mental health portion of the allocated funding, a large priority in BC was children and youth mental health: more specifically towards improving wait times for children and youth in accessing mental healthcare services (Health Canada, 2017). While there was no mention of a publicly-funded province-wide program for the province, there did appear to be an emphasis on

children and youth mental healthcare services or preventive mental healthcare, once again. The Minster of Children and Family Development, Stephanie Cadieux stated it was crucial for the province to invest in prevention and early intervention for children and youth to help ensure families had access to help early on before their issues became a crisis and ended up costing more healthcare dollars for the province in the long run (Government of British Columbia, 2017).

A few months later, on July 18, 2017, the government further elevated the addictions and opioid crisis on its governing agenda through the creation of the Ministry of Mental Health and Addictions (MMHA). Judy Darcy was appointed as BC's first Minister of Mental Health and Addictions, and the Ministry stated that they had two urgent priorities: responding to the opioid crisis working in partnership with the Office of the Provincial Health Officer and creating a seamless, accessible and culturally safe mental health and addictions healthcare system. On this latter aspect, there was an increasing emphasis on preventative mental healthcare through a comprehensive plan for children and youth mental healthcare services across the province. This again limited the focus on anxiety and depression and the corresponding commitment to the potential for broader based or larger-scale psychotherapy program. Jonny Morris, CEO of CMHA BC stated:

> "Policy space has been in short supply. The Ministry of Mental Health and Addictions when it was set up – really took on a strategic mandate – less operational – around mental health and substance use care in BC. And a lot of the much-needed policy space is taken up by the opioid crisis. Like you have a Ministry who kind of breath and depth of their mandate is absolutely mental health and reform. But I would say the policy environment or window for stepped-care – you know the policy space was consumed by other priorities…the policy space here in BC – I think is challenging given now we are looking at climate change-related mental health impacts all of these pieces are consuming – the policy space."

The seeming political indifference towards increasing access to community-based mental health treatment provision had certainly shifted in the province since the mid-2000s, albeit and perhaps cynically, due to the "ravages of the opioid crisis and the ongoing lack of coordinated response both provincially and federally to the astonishingly high and unacceptable death rates" (Morrow, 2017). Thus, the 2019 Budget for the province outlined their budget: $578M from 2017/18 to 2021/22 towards the opioid crisis in addition to the $45M for the operational

budget for the MMHA and $74M over the next three years to enhance mental health and addictions care for children and youth (Government of BC, 2019).

Symbolically, the creation of a separate Ministry of Mental Health and Addictions demonstrated the province's ongoing commitment to prioritize mental health within the broader government plans, as mental health as a policy concern had traditionally been dispersed across a range of different governmental ministries, including health, children and children and family development, and child & youth mental health. However, despite the province's decision to give mental health a new and separate "home," it was evident that the ongoing opioid crisis had caused a diversion away from broader mental health illnesses and treatment concerns such as psychological therapies.

Similarly, the BC Provincial Health Officer Perry Kendall demonstrated his concerns of the Ministry of Mental Health and Addictions being "the poor cousin" to the Ministry of Health, as most of the funding and autonomy of decisions made within the Ministry of Mental Health and Addictions come from the Ministry of Health. An example that one interviewee, a Board Member of the BC Psychological Association, provided of this was when trying to obtain funding for the integration of psychologists into primary care, they noted that their proposal and ask to accomplish this was $30M, whereas the annual budget of Minister of Mental Health Addictions had a total budget of $10M per year, which meant their proposal exceeded the ministries annual budget by $20M.[31]

In addition to the vast difference in funding and autonomy available between the Ministry of Mental Health and Addictions versus the Ministry of Health, it is important to note that the statement above sheds light on the request for coverage under BC's public health insurance, MSP, was specifically requested *only* for PhD and MA-level psychologists, who are regulated in the province, and *not* for other allied mental health professionals such as social workers, occupational therapists, and clinical counsellors. This is important given the ongoing interprofessional conflict in BC which is exacerbated through the lack of regulation of psychotherapy in the province and demonstrates the ongoing ideational contest around appropriateness of treatment providers. Another notable consideration is that advocacy for

[31] BC06, interviewed by author, June 7, 2022.

expansion in coverage for mental health services in BC has evidently been occurring in siloes and independently among not just medical providers and non-medical providers, but also among mental health service providers themselves. In BC, psychologists and occupational therapists are regulated professionals, whereas, social workers are partially regulated[32] (Lindsay, 2021) and clinical counsellors, are not (BC Health Regulators, n.d.) and thereby leading to a lack of a unified voice or a strong policy actor advocated for the system as a whole.

2019-Present Day

In June 2019, Horgan's NDP Government launched a new 10-year vision and roadmap for mental health and addictions care for the province, *A Pathway to Hope.* This strategy identified the government's immediate priorities over the next three years to help improve access to mental healthcare for citizens of BC both immediately and to reduce demand on healthcare services in the future. There was a particular and continued emphasis placed on supporting the wellness of children, youth, and young adults – with the idea of "prevention promotion and early intervention" in mental health, rather than a system solely for crisis mental health as well as the need for ongoing work to address the opioid crisis as well. Some strategic priorities included: increasing access to affordable counselling, increasing team-based primary care (with mental health providers) services, expanding Bounce Back, and opening 19 more Foundry clinics (Pathway to Hope, 2019). In other words, while the Horgan government appears to have embraced the need for a wider consideration of the mental health crisis in British Columbia, it provided no evidence nor interest within the province of adopting a province-wide psychotherapy program such as the UK's or Ontario's program. Instead, the BC government decided to continue to invest (and expand) on pre-existing smaller in focus programs, such as Bounce Back, Foundry, as well as primary care clinics.

Pathway to Hope was launched with mental health and addictions advocates at Mountainside Secondary School in North Vancouver which revealed that from 2013-2015, the number of BC students reporting anxiety and depression rose by over 135% and 50%,

[32] Social work in BC is *partially* regulated. Registration with the B.C. College of Social Workers is only mandatory for some, and there is a long list of exemptions within the Social Workers Act Regulation for social workers who aren't required to join the college.

respectively (CMHA Kelowna, 2019). Additionally, 17% of secondary students reported that they had seriously considered suicide in the last year (CMHA Kelowna, 2019). Thus, at the heart of the roadmap, was really a clear plan to begin the transformation of mental health and substance use for BC's children, youth, young adults, and their families to reach them wherever they were, in the community, school, or at home.

In November 2019, the BC Government funded 49 community agencies to expand access to counselling services. In reflection of the continuing divided nature of the mental health policy community in the province, a Board Member at the BC Psychological Association expressed disapproval of the government's decision to provide funding in this direction instead of expanding access to publicly funded evidence-based psychotherapy services. This was reflective of the seemingly limited and constrained policy environment and policy actor network in the mental health policy space. They stated:

> "You said psychological services – these places don't provide psychological services. They provide counselling services…I tried to pretend that I was a person who needed mental health services, and I came across counsellors, social workers or nurses…I didn't see any psychologists. Also, bear in mind that counsellors are not regulated in BC. So, how do we know if their mental health services effective? Do they do what they say they're going to do? Is the money well spent? How many sessions do they provide to each person? What kind of benefit is there? Maybe they're amazing, maybe they're doing some ground-breaking work, maybe the outcomes are phenomenal. Does anyone know? Is anyone doing any outcome measurements? Because it's arms-length, right? It's not THE government – it's community-based organizations that are propped up by the government and are provided additional funding."[33]

The ongoing contest over appropriate treatments and treatment providers along with the corresponding allocation of resources continued in March 2021, when the B.C. Psychological Association launched an online campaign that called for the integration of psychological care into the BC public healthcare system. The BC Psychological Association's Director of Public Policy, Lesley Lutes stated:

> "There's actually 40 years of evidence globally showing that integrating mental and behavioural health into healthcare, specifically primary healthcare works" (Hartwig, 2021).

[33] BC06, interviewed by author, June 7, 2022.

While the association acknowledged that the province funds a variety of counselling services, there were concerns that intake processes could take months and services were (as they had always been historically), predominantly only accessible through a hospital or a mental health clinic. Thus, critics of the current mental healthcare system argued that these programs were insufficient in meeting the demand and were not widely accessible for individuals.

While the mental health and illness priorities appear to have expanded to consider less acute illnesses, such as depression and anxiety, the ideational space on this front remains divided, and with a continuing priority on more acute concerns. For example, the Red Fish Healing Centre for Mental Health and Addictions officially opened its doors in November 2021 in Coquitlam, BC. Having shifted away from institutional-based care, BC's newest mental health and addictions center provided modern health services to the individuals in BC who faced both severe mental health concerns or addiction related issues. Considered, once again, the "first of its kind in North America," Red Fish was considered one of the largest, standalone centres offering inpatient care for 105 patients in the province and was dedicated towards treating the concurrent disorders of mental health and addictions at the same time (Vancouver Sun, 2022). Chief Medical Officer, Dr. Vijay Seethapathy shared that most individuals who entered the center would stay as long as nine months, which was considered much longer than most treatment facilities. This additional time provided individuals with the opportunity to understand the roots of their addictions through conventional counselling as well as different forms of existing therapies such as music, art, and physical activities (Vancouver Sun, 2022). Additionally, staff at Red Fish attempted to prepare individuals who walked through the doors of Red Fish to be integrated back into society by providing mental and health support as well as developing skills which would prepare them for employment such as computer skills, completing high school, and even cooking classes.

In January 2022, the BC Ministry of Mental Health and Addictions announced that the province would invest $4.2M towards supporting ongoing work within the 49 community agencies which were dispersed across the five regional health authorities to provide counselling services for people – with a particular focus, this time, placed on those in rural, remote and Indigenous communities (BC Ministry of Mental Health and Addictions, 2022). This funding built

on investments that the government had made since 2019 in efforts to reduce barriers in accessing mental health supports for people throughout the province. An interviewee stated:

> "They [the community agencies] have money now until March 2023 – and I think that was in response to COVID where they started with 20 and moved up to 49 agencies. And that was really to kind of reach those really hard to reach communities and in particular Indigenous communities – rural, remote so they afforded those people or agencies the opportunity to provide virtual sessions as well. And attached to that and in our Minister's 2020 Mandate Letter, it's to further explore expanding counselling to citizens or residents of British Columbia, including e-mental health options and that's part of what we're doing right now."[34]

During the pandemic, additional funding was also provided to community counselling organizations to assist them in delivering services virtually. The Government of BC notes that since 2019, approximately 25 000 people have had access to counselling as a result of these investments (BC Ministry of Mental Health and Addictions, 2022).

In April 2022, the Government of BC through the Ministry of Mental Health and Addictions announced a free counselling service for all registered post-secondary students, *Here2Talk*, which provides 24/7 mental health support and counselling, community referral services and more through a designated phone line, website, and customized app (Government of British Columbia, 2020). The provincial government is funding $1.5M per year for the service. This low barrier service came from the province's roadmap, *Pathway to Hope,* in which one of the commitments was to improve mental health supports at post-secondary.

More recently, in February 2023, the Government of BC earmarked more than $1B for mental health supports including capital investments. In terms of the distributions of the funds, Premier David Eby announced that $586M would go towards 195 new treatment and recovery beds throughout BC – in which 100 of those beds would be for community adult substance-use treatment and recovery, all publicly funded and with no additional fees attached. The remainder of the 95 beds would be dedicated to a "new model of seamless care" that aimed to help people throughout the addiction recovery process with plans to implement this model in three additional sites throughout the province. The other part of the plan was to expand the treatment model at Coquitlam's Red Fish Healing Centre – formerly known as Riverview Hospital – to provide trauma-informed practice and virtual care with incorporated physical

[34] BC08, interviewed by author, August 4, 2022.

wellness into treatment across the province as a 105-bed facility to treat people with the most severe mental health and addictions issues in the province.

Evidently, this announcement excluded any mention of preventative mental healthcare services, such as expansion of publicly funded psychological services, which had once again, been completely sidelined by the province. Green Party Leader Sonia Furstenau stated: “This budget had no investment into preventative mental healthcare like bringing psychologists under the Medical Services Plan (MSP) or hiring more school psychologists or counsellors.” Similarly, the Canadian Mental Health Association (CMHA), BC echoed that while they were pleased to see a significant investment in mental health addictions care in the province, there needed to be greater investment in harm reduction for the well-being of BC citizens.

Conclusion:

British Columbia was the one of the first provinces in Canada to introduce a publicly funded mental health program aimed at the general public and to address the emerging mental health crisis associated with mild to moderate forms of mental health concerns such as anxiety and depression. The Bounce Back program offered low-intensity mental health services which consisted of mostly self-directed forms of CBT treatment. In this regard, BC represents a quick and small policy adoption approach. A tracing of the timelines associated with the evolution, development and adoption of Bounce Back demonstrates evidence of some involvement of each of the four theoretical explanations in helping understand the policy change that took place in BC.

I. Ideas

The overall ideational policy space in relation to mental health consists of at least three main ideas:

a. mental illness priorities;
b. appropriate forms of treatment; and
c. appropriate treatment providers.

In terms of the focus on illness priorities, serious and severe mental illnesses dominated the policy space well into the 2000s and remained the primary policy focus until the mid-2000s when the 2006 Senate Report was released, which in turn BC, responded to the momentum by

adopting a low-intensity CBT-inspired mental health program, Bounce Back. Even after the shift to less serious forms of illness increased in priority, there remained continued reference to and focus on severe mental illnesses throughout the whole period in question. Eventually, and even when the ideational policy window was somewhat focused on anxiety and depression as the key priority in the mental health system, it was quickly supplanted by the evolving addictions and opioid crisis.

From a treatment perspective, the dominant focus continued to be mental health as a medical problem and one that was primarily amenable to physician-based treatments or involvement. Despite the introduction and potential of community-based treatments and a corresponding shift away from explicitly physician related treatments, Bounce Back was initially designed and intended to relieve pressure on primary care involving chronic illness and as a means of lessening the burden on family physicians and other care providers and not as a separate treatment regime for anxiety and depression. It continued in that framing throughout the whole of the time period under consideration.

Coinciding with limited forms of treatment, within the mental health community, there continued to be contests and conflict over what constituted as appropriate treatment and treatment providers. This resulted in a lack of coordinated voice within the system to advocate for a larger or expanded psychotherapy-based program to supplement Bounce Back.

II. Institutions

It is evident that policies legacies within the BC healthcare system impacted the ability of the government to introduce and expand on a larger scale psychotherapy-based program. In particular, the organization of the health care system around medical professionals, and physicians in particular, meant that any type of reform had to fit within this model or, at the least be acceptable to those institutionalized interests. As a result, Bounce Back was not – at least initially – designed or sold to the medical community or the broader public as a treatment program for the crisis in less acute types of mental illness. Rather acceptance of the program was predicated on it being sold to the medical community as an adjunct to the existing primary care model and one that would reduce their workload and stress.

In addition, the lack of coordination among the mental health community, including the lack of professional regulation of the range of mental health care providers, meant that no clear voice represented a broader interest supporting an expanded or larger publicly funded mental health program. To the contrary, the evidence demonstrated a lack of coordination and continuing conflict over and attempts at protecting mental health treatment spaces as ones that existed or "belonged" to particular care providers.

III. Policy Entrepreneurs

Once asked by the BC government to investigate potential solutions to the evolving mental health crisis in BC (and elsewhere in Canada), CMHA – BC became an influential policy entrepreneur in relation to the initial policy response of the government. CMHA – BC invested its reputation as experts in mental health to investigate the range of policy options to address the crisis and its time and the resources provided to by the government. It drew on the ideas about proper treatment from Dr. Williams and the program established in the UK and modified those to fit the policy environment in BC and proposed those findings to the BC government for its adoption. They advocated for a modified program that would start small and build from the initial foray into the mental health policy space.

However, as quickly as the government provided CMHA – BC with importance and influence, it took it away. Once CMHA – BC had fulfilled the government's initial request by investigating and recommending a policy solution to the evolving less acute mental health crisis, the government was less responsive and sympathetic to their efforts at expanding beyond the original Bounce Back program. In this regard, CMHA – BC's policy entrepreneurship came to an abrupt end as the government moved onto other mental health concerns and health crises.

IV. Policy Learning

In terms of policy learning, there is clear evidence that this occurred in BC. CMHA – BC did not design the Bounce Back program on its own, but rather adopted part of the existing program from the UK and under the guidance of Dr. Williams. It copied part of the program from the UK and adapted it to meet BC needs. However, once the government adopted the

program for its own needs, it was grafted onto existing problems within the system and was therefore sold as an adjunct to the existing health care crises in chronic illness treatment.

As is evident from this discussion, there are intersections between the theoretical explanations that provide insight into both policy stability and policy change – that as the ideas associated with mental health, mental health treatments and mental health treatment providers were in flux, there was space for policy entrepreneurs who had learned from other efforts to address a similar policy problem to provide advice to government, albeit constrained to some extent by existing policy legacies.

List of Mental Health Reports in British Columbia

1. **Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital, 1987**
    a. Riverview hospital was a treatment, rehabilitation and asylum center for adult and elderly people. This consultative planning process outlines the provincial philosophy and principles, as well as identifies the target population and need for service developments in terms of the current medical services available. The report discusses day programs, community residential care, outpatient treatment and case management, hospital care, services for the elderly, system coordination and accountability, recruitment training, and development of personnel.
2. **Revitalizing and Rebalancing Plan, 1998 (pg. iii)**
    a. The Government of BC released a new seven-year mental health plan, *Revitalizing and Rebalancing British Columbia's Mental Healthcare System*, is a consultative planning process document outlines the provincial philosophy, principles, target population and need for service developments in terms of the current readily available mental healthcare services. Specifically, the plan outlines a focus on the following critical issues:
        - An emphasis on adults with the most disabling functional impairment due to serious mental illness;
        - An emphasis on early identification and treatment of individuals and related support for families;
        - Implementation of best practices in mental healthcare to enable consumers to benefit from the current knowledge about program and service design that produce positive outcomes;
        - More responsive services for individuals with multiple problems, who historically have been poorly served by existing services (e.g. people with mental illness and substance misuse issue and/or have been in conflict with the law)
        - A shift in service delivery to better respond to individuals' complex needs through outreach, assertive case management and appropriate medical care in non-hospitals settings whenever this is consistent with quality care;
        - Policy development and service planning coordination focused on the biological, psychological and social needs of people with serious mental illnesses
        - Integration of forensic psychiatric services with other elements of the mental health system;
        - Improved policy coordination with other ministries to better address income security, housing, training, employment and other social support needs
3. **Provincial Anxiety Disorder and Depression Strategies, 2002**
    a. This two-part report (Provincial Anxiety Disorders Strategy released in April 2022 and Provincial Depression Strategi, released in October 2002), which was funded by the BC Ministry of Health, is strongly focused on the prevention, public awareness, evidence-based practices, as well as the use of an expert panel approach to identify initiatives for depression and anxiety. The document defines the costs of two

disorders – to the society as a whole and to the individuals who are afflicted – which results in proposing a strategy for preventing and treating these disorders.

4. **The Picture of Health: How we are modernizing British Columbia's health care system, 2002**
    a. This report provides a detailed description of the direction of BC's healthcare system. Specifically, with regards to mental health, the report discusses the current state of mental health in BC, and proposes a few key strategies to revamp the mental healthcare system:
        i. Improving access to community-based options
        ii. Mental health information for individuals and families
        iii. Implementing quality practices
        iv. Developing provincial tertiary services
        v. Child and youth mental health services
        vi. Provincial depression strategy
        vii. Provincial anxiety disorders strategy
5. **Children and Youth Mental Health Plan (CYMH) for British Columbia, 2003**
    a. The aim of this report is to "better meet the mental health needs of children as new approaches and additional resources are urgently needed." Specifically, there is a need for: more timely and effective treatment and support services for children with serious mental illnesses; programs that reduce risk, prevent, and mitigate the effects of mental illness; new efforts which improve the capacities of families and communities to prevent and/or overcome the harmful impacts of mental illness is children; and, better systems to coordinate services, monitor outcomes, and ensure public accountability for policies and programs.
6. **Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia, 2010**
    a. This report emphasized that children, youth, and adults with mental health and/or substance use concerns with mild to moderate symptoms "could be effectively supported or treated through low-intensity community services." The plan discusses that the Bounce Back program, increases the availability of low-intensity interventions which allows for serving a larger pool of individuals in the province. The province further elaborated on this statement in that this would be done through enhancing the role of primary care, availability of evidence-based therapeutic approaches and community-based mental health and substance use services
7. **Pathway to Hope, 2019**
    a. In June 2019, Horgan's NDP Government launched a new 10-year vision and roadmap for mental health and addictions care for the province. This strategy identified the government's immediate priorities over the next three years to help improve access to mental healthcare for citizens of BC both immediately and to reduce demand on healthcare services in the future. There was a particular and continued emphasis placed on supporting the wellness of children, youth, and young adults – with the idea of "prevention promotion and early intervention" in mental health, rather than a system solely for crisis mental health as well as the need for

ongoing work to address the opioid crisis as well. Some strategic priorities included: increasing access to affordable counselling, increasing team-based primary care (with mental health providers) services, expanding Bounce Back, and opening 19 more Foundry clinics.

CHAPTER 5: ONTARIO'S PATH TO ADOPTING A PUBLICLY FUNDED PSYCHOTHERAPY PROGRAM

In contrast to the experiences in British Columbia, where the pursuit of publicly funded and community-based mental health services to treat mild to moderate mental health concerns, such as depression and anxiety, happened relatively quickly following the release of the Kirby Report in 2006, Ontario moved more slowly and cautiously before eventually adopting a low and high-intensity CBT program, the Ontario Structured Psychotherapy Program (OSP).

OSP is described as a province-wide stepped-care CBT program that provides evidence-based, cognitive behavioural therapy (CBT) to Ontario citizens. All OSP services are based on CBT approaches as CBT teaches people how to change and recognize their patterns of behaviour and thinking (Government of Ontario, 2024). The CBT approach can thus lead to better mental health and ability to cope and manage difficult emotions and situations. The OSP program is the first-of-its-kind in Canada and helps people that suffer with common mental health disorders, such as anxiety and depression, to develop lifelong skills that are needed to build resilience and manage their mental health. The program is based on the UK's nation-wide publicly funded psychotherapy program, Talking Therapies (formerly known as *Increasing Access to Psychological Therapies* (IAPT)).

The OSP program offers two types of CBT therapy, low and high intensity.

- Low Intensity consists of self-led resources which are guided by a coach or therapist (Ontario Health, n.d.):
    - **Bounce Back:** workbooks, videos, telephone calls with a trained coach.
    - **Clinician-Assisted Bibliotherapy:** readings, exercises, and brief one-on-one therapy sessions to support the main takeaways.
    - Internet-based CBT guided by a therapist and includes modules, readings, and exercises that help in learning coping and resiliency skills.
- High intensity consists of **Therapist-led CBT**(Ontario Health, n.d.)**:**
    - One-on-one or group sessions
    - In-person or online

In most cases, individuals will begin the OSP program at the low intensity level with self-led resources as the first step. A care team will closely monitor the client, and if it is determined that they require more support, they can move to a higher intensity service within the program: individual or group therapist-led CBT. To participate in the OSP program, a patient needs to be 18 years of age or older and experiencing symptoms related to depression or an anxiety-related disorder. To register, one can self-refer or register themselves, or speak to their doctor or healthcare team for a referral. A Health Card is not required to access OSP services.

This chapter delves into the details of Ontario's experiences as the first province in Canada to adopt a more comprehensive and publicly funded psychotherapy program as it moved through four seemingly distinct periods of shifting mental health focus and treatment:

1. The deinstitutionalization period leading up to and including 1980s and where severe mental illnesses defined the focus of treatment and services,
2. The cost-cutting and budget reduction focus of the 1990s and with a continuing prioritization of treatment and services for severe mental illnesses,
3. The rise in concern with mild to moderate mental illnesses, such as depression and anxiety, and the Kirby Report of the mid-2000s, and
4. The slow and incremental progression of the late 2000s through the middle of the next decade, and with an initial focus on youth mental illnesses of all levels of severity and culminating in the expansion of mental health care for less serious mental illnesses through the piloting of the OSP program.

The story in Ontario is one of evolution – evolution of the policy priority focus, the scope of treatments and services available and appropriate to treat mental illnesses in the province and the range of appropriate treatment providers – that ultimately culminates in a fifth period with the adoption of the OSP (the slow and big outcome). This outcome in Ontario is explained by the roles and ideas of the actors that pushed for mental health reform and change, which were highly evident in the province. In particular, there was:

(a) The presence of strong ideas among healthcare leaders and providers in the province that mental health treatment did not have to necessarily be provided by medically

trained professionals, but could also be delivered by or through allied mental health professionals;

(b) Entrepreneurial activities undertaken by prominent policy actors in both the healthcare and government space who advocated for expanding access to publicly funded psychotherapy in the province;

(c) Policy learning from both outside the province and from within its existing healthcare providers and institutions.

I. DEINSTITUTIONALIZATION

Early Beginnings of Mental Healthcare Delivery in Ontario

Similar to many jurisdictions across Canada, Ontario faced a lengthy struggle to achieve mental health reform until the latter part of the 1980's, when efforts to achieve comprehensive reform of the much-needed systems-level finally took place. The catalysts for these reforms were attributed to two external reports that highlighted the lack of community-based mental health services and the 1988: *Building Community Support for People: A Plan for Mental Health in Ontario* (also known as the Graham Report). Even more importantly, the province saw an end to the more than four decade long Conservative government rule (Hartford et al., 2003).

Liberal Party

(i) David Peterson (1985-1990)

David Peterson's Liberal Party win in 1985 was a major change for the province after more than four decades of Conservative leadership. Upon entering office, Peterson moved quickly on key policy issues, such as healthcare. In the Throne Speech in November 1987, the Peterson Government announced a new strategy for healthcare in the province. The intent was to redirect the healthcare system away from heavy reliance on hospitals and physician-based care and towards the development of community-based services, health promotion, and disease prevention instead (Barker, 1990). In other words, even at the time, Peterson strongly believed in the value and effectiveness of preventive healthcare.

Regarding mental health reforms, this was the era that Ontario's first ever comprehensive investigation into mental health in the province. It culminated in the *Graham Report* that was

released on July 28, 1988. The vision and goals of the Graham report were in alignment with and reflected what the Peterson government had in mind for the broader healthcare system in the province – a plan for the development and implementation of a comprehensive community-based mental healthcare system. The report stated that following the election of the Peterson government in 1985, there had been a 65% increase in funding towards community mental health programs. This followed Peterson's announcement to double mental health spending by 1990 and in line with the recommendations made by the Ontario Health Review Panel in June 1987[35] and other groups to enhance the capacity of local communities to provide more community-based mental healthcare. The Ontario government stated that its new partners, consumers and their families, would help create an improved mental health system (Graham, 1988). The creation of the Premier's Council on Health Strategy, following the government's re-election in 1987, was made up of government ministers and medical experts alike to serve as a forum when considering difficult decisions to be made in the province regarding healthcare dollars. It was led by Peterson himself and ultimately released a series of reports in the Spring of 1991 (shortly after the election of the NDP under Bob Rae) that included recommendations to provide greater healthcare services, including mental health care, in the community and through local agencies (Lavis et al., 2013; Spasoff, 1992).

In terms of discussing the strategic plan to strengthen and advance the province's mental healthcare system, the Graham Report (1988) proposed a 10-year long-term plan for the development and implementation of a community based mental healthcare system. The report recommended that people who suffered from serious mental illnesses or disabilities should be considered a priority. There were also some other notable and interesting findings mentioned in the Graham Report (1988), such as how following the creation of universal hospital and medical insurance in Canada in the late 1950s and early 1960s, the downturn of the economy and its accompanying life stressors had resulted in an increased use of mental healthcare services. In

[35] The Evans Panel, formally known as the Ontario Health Review Panel and chaired by Dr. John Evans, was a 10-member panel appointed by the new Liberal government in 1986 with a mandate to take a fresh look at health policy in the province after four decades of Progressive Conservative rule. The Panel reported to the Premier in June 1987 and "identified three priorities for health policy: (i) a strengthened role for the individual; (ii) linking the elements of health care delivery and increasing the emphasis on ambulatory and community-based care; and (iii) achieving a strategy for health in Ontario." (Spasoff, 1992).

other words, while the report acknowledged serious mental illnesses as the primary focus, the conversation surrounding mental health had begun to shift and was not just solely focused on severe mental health concerns as it historically had been.

The report stated that there had been "changing public attitudes towards emotional problems, psychotherapy, psychoanalysis, [and] in conjunction with increased availability of services under OHIP, [this] led to the increased utilization of mental health services by individuals who, previously, would not have used a mental health hospital" (The Graham Report, 1988: 27; Mulvale et al., 2007). The report also revealed that in many parts of Ontario, "the bulk of mental health [was] the responsibility of family physicians or public health nurses [and that] these health workers usually [did] not have sufficient or readily available psychiatric back-up at their disposal" (The Graham Report, 1988: 38). Thus, the report proposed that "psychiatrists and allied health workers should become more involved in non-hospital based mental health programs" (The Graham Report, 1988: 47) and that rather than providing the traditional role of just hospital-based treatment, that psychiatrists should also be available to provide telephone advice or be available outside of their regular consultation hours in addition to facilitating hospital admissions and advocating on behalf of programs and their clients.

The key focus on mental health care in the province in this era demonstrated a changing attitude to treatment provision, with a focus on shifting out of institutionalized care and into the provision of treatment in community settings or by local agencies, both in general and for mental health care more specifically. At the same time, however, while there was some recognition of less severe illnesses, the priorities of mental health care continued to focus on severe illnesses, medical-based treatments provided by physicians and, to a lesser extent, mental health nurses.

II. DEFICIT REDUCTIONS AND COST-CUTTING

New Democratic Party Government

(i) Bob Rae

In the early 1990's, there were no major or notable broad system-based health reforms which took place under the NDP government. However, a notable policy failure that occurred

under Rae's tenure was the decision to attempt to reduce healthcare costs by placing caps on enrolments in medical schools, reducing residency positions, which contributed to the significant shortage of specialists and family physicians in the early 2000s.[36] At the time, the Rae government believed that the reason for rising healthcare costs was "too many doctors ordering too many tests, providing too many procedures and prescribing too many medications (Toronto Sun, 2015)." Despite repeated warnings from the medical professionals and associations alike in 1992 that this policy decision would lead to severe physician shortages in the decade to follow (taking into consideration the time it takes to train a doctor), Rae and his government, like others across the country, ignored these precautions and still forged ahead with a focus on cost reductions (Geiger, 2008). As primary care physicians serve as the main point of contact for many mental health services, this placed a further strain on an already undermined area of healthcare such as mental healthcare (Kates et al., 2019).

In terms of mental health initiatives, in 1993, the report *Putting People First: The Reform of Mental Health Services in Ontario* was released, as a policy framework aimed to transform mental health services across the province (Government of Ontario, 1993). This framework endorsed the 1988 *Graham Report* and provided a central focus for development of this policy through proposing a 10-year plan for mental health reform in Ontario based on common visions and values. It also reconfirmed that priority should be given to services for individuals facing serious mental health illnesses. It stated that the goal of the Ministry of Health and Long-Term Care should be to allocate 60 percent of the mental health funding envelope to community-based services and 40 percent towards hospital care by 2003, which was a reverse of the initial funding allocations at the time. Following this, in 1994, the report for *Implementation Planning Guidelines for Mental Health Reform* (Government of Ontario, 1999) was released which set out the clear expectations for District Health Councils and their role in mental health reform based on the 1993 *Putting People First* report (Government of Ontario, 1993). During this time-period, while we do see an incremental build-up and interest towards addressing mental healthcare within the province, we also see the continuing transition and shift in ideas from hospital-based

[36] Rae is widely remembered for proposing that the number of physicians in Ontario be cut by 10 percent, which was reflected in the decrease of medical school enrolment in September 1993.

psychiatric mental healthcare to community-based services and programs (Mulvale et al., 2007). However, at this stage, in terms of the target population for mental healthcare services, there was still a strong focus on treating serious mental illnesses through the traditional medical model rather than preventative mental healthcare services or mild to moderate mental health disorders and despite the recognition of the increasing significance of less severe mental health conditions (Roennfeldt et al., 2024; Stergiopoulos, 2016).

Progressive Conservatives (Harris & Eves Government)

In the early-1990s the province of Ontario experienced a significant economic crisis. To counter this, upon election, Harris Progressive Conservative government immediately implemented a massive reform agenda in an effort to cut the large provincial deficits that had accumulated under the previous government. As part of its reform agenda, the government established the Ontario Health Services Restructuring Commission (HSRC).

Considered the centerpiece of its healthcare reforms, the HSRC was created primarily to restructure hospitals in Ontario with the primary goal of containing costs within the system (Cohn, 2001). The HSRC was empowered to direct hospitals to amalgamate, transfer, accept programs, change their volumes, or cease to operate along with any other changes considered to be in the public interest. The first half of the mandate consisted of downsizing the hospital sector, closing 40 hospitals and reducing other healthcare services throughout the sector and across the province. The hospital-focused actions drastically reduced the number of acute beds and involved the closing of institutions. Specifically, the HSRC closed 31 public, 6 private, and 6 provincial psychiatric hospital sites (Sinclair et al., 2005; Tobin,2017). Furthermore, shortly before the announcement of the HRSRC, the Harris government announced the decision to layoff several hundred nurses to additionally cut costs from the delivery of healthcare. While the HSRC did recommend increasing spending on comprehensive team-based primary care, it was simply not enough to sustain the population. Moreover, while the intent of restructuring was to reshape the hospital sector, this had an unavoidable implication on the healthcare sector's weakest link: mental health. For individuals requiring mental health supports within the

community, the available services were simply insufficient (Sinclair et al., 2005; Wiktorowicz, 2008).

In 1998, the Progressive Conservative government issued its first report on mental health; *2000 and Beyond: Strengthening Ontario's Mental Health System* (Newman, 1998). It was based on a series of consultations, led by Dan Newman, an MPP and Parliamentary Assistant to the Minister of Health and Long-Term care. This report reviewed actions undertaken pursuant to the 1993 report, *Putting Peoples First,* (and which had been endorsed by the Rae government) and found, that despite the recommended funding allocations, the previous goal of the Ministry of Health and Long-Term Care be to allocate 60 percent of the mental health funding envelope to community-based services and 40 percent for hospital care had not yet been implemented.

In addition, and as part of the ongoing consideration of restructuring the hospital sector, in 1999, the HSRC recommended to the Ministry of Health and Long-Term Care that nine of Ontario's provincial psychiatric hospitals (PPHs) be transferred to local community services and/or to community hospitals. It also recommended that an estimated $83-87M be allocated in transitional funding to allow for the services to be established before beds were closed. This would result in fewer hospitalized patients per year and a decrease in funding towards psychiatric hospitals, as well as a concurrent shift of resources to community-based mental health programs that were non-existent at that time. Given that these psychiatric hospitals also served as homes and beds for many patients, the need for homes to house these patients also increased. In the 1999 report, *Making it Happen: Implementation Plan for Mental Health Reform*, the Ministry's strategy regarding the transition from PPHs to community-based care was mentioned, as well as the recommendation of transitional funding to support the transition to community-based mental healthcare programs. The Ministry also made the commitment to continued investments/reinvestments in mental health services to "support mental health reform and increase overall capacity of the system." Lastly, consideration for a follow up review in 2002 was stated as being necessary in the report regarding the implementation of the strategies and funding priorities.

In 2002/2003, the Mental Health Implementation Task Force, which was convened in 1999 to provide recommendations and advice to the Ministry of Health and Long-Term Care regarding the implementation of a reformed mental health system in Ontario, provided a final report called *The Time is Now*. This report was a collection of the consultations the task forces had had over a 3-year period with thousands of individuals in the field of mental health. Some of the recommendations within the report included:

- implementing regional decision-making to improve local delivery systems;
- increasing peer and family supports for individuals facing mental health struggles;
- an emphasis on early intervention and treatment;
- greater system accountability, performance standards and information systems; and
- appointing a provincial team to ensure the priority of achieving mental health reform remained on the provincial agenda.

While improved access and expansion of mental healthcare services failed to occur under Harris' leadership and direction, there was the emergence of the beginning of a shift in ideas. Mental health advocates and policymakers alike requested greater improvements on the state of the mental healthcare system broadly speaking. More specifically, there was a greater emphasis on regional and local supports to ensure the services correlated with the populations' mental health needs and a continuing shift away from institutions and onto community-based treatments and services. There was also an increasing focus on three other aspects, namely:

a) early intervention and treatment as opposed to crisis based mental health services,
b) greater system accountability regarding performance standards on the existing mental health services; and
c) lastly, ensuring mental health reform remained a priority on the provincial agenda.

Despite the potential for these new ideas to open up space in the mental health policy sphere, most of the changes pursued during this time were focused on eliminating over capacity and

reducing costs in the system (Cohn, 2001; Wiktorowicz, 2008). The result was little change to the foundational ideas underlining the delivery of mental health care in the province, with a continuing focus on severe mental illnesses and the medical model of treatment overall and with a corresponding reliance on physicians, albeit with some receptiveness to other types of treatment providers.

III. THE SHIFTING AGENDA AND THE RISE OF DEPRESSION AND ANXIETY

Liberal Government

(i) Dalton McGuinty (2003-2013)

in 2003, Ontario faced a change in government and leadership, when Dalton McGuinty was elected as Premier of a Liberal government. Unlike his predecessors, McGuinty's Liberal government placed an emphasis on increasing spending on healthcare and education, particularly from 2003-2007 before the 2008 financial crisis. A major platform of his Liberal Party was to modernize the healthcare system in Ontario. One of the major health reforms that took place early into the new government's tenure in May 2004, was the introduction of 150 Family Health Teams (FHTs), to improve primary care for 2.5 million Ontarians (Government of Ontario, 2004). McGuinty stated that FHTs would provide team-based "around-the-clock health care" and consist of a team of doctors, nurses, nurse practitioners, and other allied healthcare professionals such as social workers and psychologists, in order to improve and streamline healthcare delivery within the province. For mental health, this was also promising as primary care physicians serve as the first point of contact for providing referrals or offering mental healthcare services themselves in the province. Thus, the idea of having allied mental health healthcare professionals working alongside a primary care physician in a single setting sounded appealing, as it would both improve the quality and delivery of care. Moreover, the introduction of interdisciplinary FHTs as part of Ontario's primary care strategy presented an opportunity to overcome the lack of funding for non-physician mental health providers; while also advancing community-based collaborative mental healthcare (Mulvale et al., 2008). By the end of McGuinty's tenure, Ontario's FHTs had grown to a total of 200, which provided healthcare to

approximately 3 million Ontarians, until the province quietly pivoted away from the team-based model later in its mandates (Ashcroft, 2016).

Shortly after, on April 1, 2007, a major health reform was undertaken by the government and consisted of the introduction of the 14 Local Health Integration Networks (LHINs). In response to the province's fragmented healthcare system, the LHINs were mandated, each with their own board of directors, to plan, and integrate the delivery of healthcare services and to distribute provincial funding for all public healthcare services at the regional level. Since their creation, LHINs played a prominent role in working with local healthcare providers and community members to determine the health service priorities within each region, including;

- funding local health services, including public hospitals;
- integrating health services;
- facilitating publicly funded homecare;
- providing school health support services; and
- overseeing Community Care Access Centres (Armstrong & Armstrong, 2018; Government of Ontario, 2007)

With respect to the delivery of mental health, as with other healthcare services, this major reform, was again promising as the LHINs aimed to bring together different healthcare providers and organizations, which in turn would enhance access to mental healthcare services. When coupled with the introduction of the Family Health Teams, there is further evidence of the opening up of treatment spaces and health services delivery to incorporate broader interests than inherent in the medical model.

Coinciding with this reconfiguration of the broader and systemic ideas around the provision of medical and medical related services was the introduction of the *Psychotherapy Act, 2007* which sought to formally regulate the provision of psychotherapy services within the province, including the recognition of a range of potential treatment providers and recognition of the practice as part of the suite of mental health treatments. The *Psychotherapy Act, 2007,* was established in light of the long history of contestation and ambiguity surrounding the definition of psychotherapy and who could practice the delivery of psychotherapy services. This contestation had existed for decades in Canada but also internationally, which has stirred

tensions in the mental health community (Vesely et al., 2022). This is in part due to the psychotherapy's broad and varied methodological and theoretical practices (Cook et al., 2017). Unlike medicine where specialities and the scope of the work physicians provide are more specific, psychotherapy can and was recognized as being delivered by a wide range of medical (i.e. psychiatrists, family physicians and nurses) and non-medical providers (i.e. psychologists' social workers and occupational therapists) with varying level of education and skillsets. When a profession or healthcare practice is unregulated, this creates risk of malpractice (via informal education and/or training). This sparked a public outcry as people were being harmed by untrained practitioners and there were no regulatory bodies to hold these individuals accountable (Benjamin, 1986). Thus, defining and legitimizing the professional boundaries by legally recognizing and unifying professionals through practices is important. Thus, the 2007 Act was an important historic moment for a wide range of mental health practitioners in Ontario as it established the *College of Registered Psychotherapist of Ontario (CRPO),* which regulated psychotherapy providers in the province, while protecting members of the public (Vesely et al., 2022). However, given the complexities associated with establishing the boundaries, standards and guidelines around accepted practices as well as the need for a number of different professional regulatory bodies (such as colleges of nurses, physicians, occupational therapists, psychologists and social workers) to also develop standards and guidelines, a long implementation period appears to have been required and incorporated into the regulation (Dresher, 2017; Vesely et al., 2022). Underlying this whole process was a clear and greater receptivity to the practice of psychotherapy by a range of treatment service providers as opposed to being restricted to a single profession.

IV. THE PRIORITIZATION OF CHILDREN AND YOUTH MENTAL HEALTH

The next major development in the mental health policy space in Ontario took place in 2008, when the McGuinty government made a commitment to strengthen mental health and addictions services in the province, including decreasing wait times in emergency departments for people with mental health and addictions concerns and providing better support for eating disorders (CMHA Ontario, 2009). In October 2008, the government established an Advisory

Group made up of people in the province with lived-experiences, family members, service providers and researchers to help develop a ten-year strategy to transform mental health and addictions services within the province (CMHA Ontario, 2009).

In 2009, the Government of Ontario released its new strategy *Every Door is the Right Door,* which proposed a ten-year plan for mental health and addictions treatment provision within the province. This report was important because it specifically broke down the costs of mental health and addictions in Ontario and made the case that investing in mental health could end up saving the government money in the long-term. The report detailed the costs of mental health and illness on the province was $39B and stated that "every $1 spent on mental health and addictions saves $7 in health costs and $30 dollars in lost productivity and social costs" (CMHA Ontario, 2009:16).[37] Alongside many recommendations, the report proposed "early identification and intervention" for "those at risk or those with early symptoms of mental illness or addiction (CMHA Ontario, 2009)." In this case, this is evidence of Ontario's changing ideas towards problem-framing for mental healthcare services by proposing that investing in community-based mental health services such as psychotherapy could result in cost-savings.

In February 2009, alongside the government's new mental health strategy and evidencing the increasing priority of non-severe mental illnesses on the policy agenda, the legislature formed an all-party Select Committee on Mental Health and Addictions to develop a comprehensive mental health and addictions strategy. The non-partisan makeup of the committee improved the likelihood of the strategy being accepted and supported by each of the parties in the event that there was a change in political leadership in Ontario (Bullock & Abelson, 2019). The Select Committee began to work on three key priority areas:

[37] This justification for an increased budget was framed as and similar to a strategy the two key policy entrepreneurs undertook in the adoption of the United Kingdom's nationwide publicly funded psychotherapy program, *Talking Therapies (formerly known as Increasing Access to Psychological Therapies)* - Richard Layard, a leading labour economist and David Clark, a psychologist framed the policy issue and made a case for the financial benefits of adopting a nationwide publicly-funded psychotherapy program to the Labour Government under Tony Blair in 2006. Layard and Clark presented a cost-benefit analysis which demonstrated that while there would be upfront costs, the program would eventually end up paying for itself in five years (D. Clark et al., 2007; Layard, 2006). They proposed that treating psychological problems through publicly funded therapy would generate massive savings on the healthcare system as a whole but also, economically through more people being able to work – and in turn, this would pay for itself (Layard et al., 2015).

1) to determine the mental health and addictions needs of children and young adults, First Nations, Inuit, Metis peoples, and seniors;

2) to explore innovative ways of delivery services in the community; and

3) identifying ways to leverage existing opportunities and initiatives within the current mental health and addictions system in Ontario (Ontario Legislative Assembly, 2010).

Coinciding with the prioritization of less severe mental illnesses, such as depression and anxiety, was the advocation for and recognition that different types of treatments and treatment providers could also provide assistance in ameliorating the evolving mental health crisis. In this regard, the Select Committee opened up the space for new considerations of appropriate treatments during its hearings into the provision of mental health services. For example, in June 2009, Dr. Annette Dufresne, a clinical psychologist presented to the Select Committee discussing the importance of psychotherapy as a treatment for mental health disorders. She outlined the range of interventions used in psychotherapy, as well as the existing research supporting its uses and potential avenues to expand access within the country, making references to international publicly funded psychotherapy such as the Australian model (LAO, 2009a). Later that year, in September, the Alliance of Psychotherapy Training Institutions also presented to the same committee, providing additional information on the power of psychotherapy in the form of a publicly funded health service (LAO, 2009b). Later that month, the Ontario Coalition of Mental Health Professionals also presented to the Select Committee furthering Dr. Dufresene's case by arguing that the development of practices and policies are needed to provide Ontarians with accessible psychotherapy services (LAO, 2009c). In August 2010, the Select Committee on Mental Health and Addictions released its final report in an attempt to educate politicians and advocate for organizational realignment, improved access to mental health services, reformed physician remuneration models, and to increase the availability of affordable housing amongst other recommendations (LAO, 2010). Most notably and reflecting the testimony it received from these three examples and others, the Committee's report endorsed including publicly funded psychotherapy as part of the solution. Implicit in this outcome and coinciding with the introduction of the Psychotherapy Act, 2007

was the recognition and understanding of the need for an expansion of the range of both appropriate treatments and treatment providers beyond the purely medical model.

Following this, in 2011, the trajectory towards the adoption of a province-wide psychotherapy program in the province began to take greater shape. The province introduced the first phase of the *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, which outlined the Ministry of Health and Long-Term Care's (MOHLTC) 10-year strategic plan towards addressing the need to support mental health through integrated services for Ontarians. The first priority, and one that remained high on the government's agenda was the focus on the mental healthcare services for children and youth. McGuinty announced in 2011 that his government would invest $257 million over the next three years to help 50 000 youth deal with mental health issues (Government of Ontario, 2011a). His plan targeted "faster access to services, more early identification of problems, and a wider range of supports" (CBC, 2011). This expansion simultaneously meant hiring more mental health workers within schools and in the youth court system as well as additional funding being allocated to community agencies and expanding video-based counselling services for youth to further cut down on the wait times for access.

The plan outlined that during the first three years, the province would prioritize children and youth, as much as a preventative measure as well as a treatment option. Data showed that 70 percent of adults living with mental health problems had their onset during their childhood and adolescent years, and many did not receive nor had access to the required treatments early on (CIHI, 2023; CMHA Ontario, n.d.; Kessler et al., 2007). As a result, the province proposed a mental health strategy that prioritized children and youth and that would offer significant benefits as well as save healthcare dollars in the end. In other words, there was strong evidence of ideas within the province (which were backed up by data and research) that given that a large percentage of mental health concerns occurred in the early years of life, there was a benefit in prioritizing and investing in preventative mental healthcare services. This is continuing evidence of the shifting in overall priorities away from the treatment of severe mental illnesses and on a crisis basis and towards more holistic and community centred

approaches and with a corresponding reliance on different types of treatments and treatment providers.

Phase I of the *Open Minds, Healthy Minds* report launched in 2011 focused on four key pillars (Government of Ontario, 2011b):

1. Improve mental health and well-being for Ontarians;
2. Create healthy, resilient, inclusive communities;
3. Identify mental health and addictions problems early and intervene;
4. Provide timely, high quality, integrated, person-directed health and other human services.

In November 2012, the provincial government released another report that focused on the province's mental health priorities on children and youth: *Moving on Mental Health: A system that makes sense for children and youth.* The report was generated in collaboration with various ministries within the province, including Children and Youth Services, Education, Health and Long-Term Care, and Training, Colleges and Universities. This collaboration was likely because at the time, there was not a dedicated Ministry of Mental Health and Addictions, thus, given that mental health intersected with multiple social and health issues, the relevant ministries decided to collaborate to tackle children and youth mental healthcare. This report outlined a targeted action plan to ensure the improvement of children and youth mental health services within the province. Some of the goals were (CMHA Ontario, 2012):

- defining a core set of children and youth mental health services that would be available to communities across Ontario;
- establishing community agencies to lead the delivery of mental health care; and
- building a regulatory framework for these agencies to ensure a consistent quality of care throughout the province.

This was important because not only was the province focused on developing a mental health strategic plan – which they had done in previous years, but they were taking it a step further to try and ensure the quality of care that was delivered was consistent and continued to move away from institutionalized care.

V. THE EXPANSION TO OSP

(i) Kathleen Wynne (2013-2018)

On February 11, 2013, Kathleen Wynne became the province's first female premier. She pledged if her Liberal government were to be re-elected, every Ontarian would have access to primary care by 2018. Statistics Canada, at the time, showed that 92.5 percent of Ontarians had access to a primary care provider – either in the form of a family physician, general practitioner, or a nurse practitioner in smaller communities. However, in 2014, Wynne stated that she would not be satisfied until this number reached 100 percent. This turned out to bit too ambitious as a 2016 survey showed that the number had instead declined to 90.3 percent – which meant that in a population of 14 million, approximately 1.3 million Ontarians still did not have regular access to primary care in 2016. This was particularly concerning as primary care providers are the gatekeepers to other services, such as mental healthcare services.

The Wynne government continued the efforts of its predecessor in trying to rationalize valuable health care resources while remaining committed, at least rhetorically, to an expanded and improved health care system from that of the previous Progressive Conservative governments of Harris and Eves (Evans & Fanelli, 2018). In keeping with this approach, Wynne sought out expertise to justify and legitimize the paths chosen by her and the McGuinty government. Both an example of and significant development associated with this occurred in June 2014, when Dr. Robert Bell, a former orthopedic cancer surgeon and CEO of University Health Network was appointed as Deputy Minister of Health and Long-Term Care. At first glance, Dr. Bell would have been an unconventional selection for a Deputy Minister despite having had a long, successful international career within medicine as a surgeon, clinician-scientist, and healthcare executive as CEO of Toronto's University Network Hospital (UNH). The fact that he had never worked in a government setting before marked him as an atypical appointment (Evans et al., 2014). However, former Health Minister Deb Matthews stated that this appointment could serve as an advantage and that the former orthopedic surgeon could "really drive change" given his practical knowledge of the healthcare system (The Globe and Mail, 2014). Many believed that Dr. Bell's background would help him in this new position as he had an insider's hands-on and real-world knowledge of front-line healthcare from being a

physician and CEO that many politicians and career bureaucrats did not have. This, in turn, would enable him to provide an outsider's perspective from that of the typical "cookie cutter" bureaucratic leader. Graham Scott, a healthcare consultant and former deputy minister in the 1980s, stated in the media that he also believed Dr. Bell's credibility would serve as an important asset:

> "Generally speaking, it's really hard to recruit external people in the Ministry of Health. Yet external people can be of enormous value because of their hands-on experience in running the system. That's why I think this is a considerable coup for the ministry (The Globe and Mail, 2014)."

Scott's statement is valuable as it is certainly more common to select Deputy Ministers from a pool of candidates who have previously held senior leadership positions within the provincial or federal government – thus, there was recognition from healthcare leaders themselves that this was considered uncommon and out of the norm. However, as a physician who was not previously part of the mental health and political space, there was an expectation that Dr. Bell would bring forward a different perspective to the role.

In November 2014, shortly after Bell's appointment, and under his leadership, the Government of Ontario created the Mental Health and Addictions Leadership Advisory Council to advise the Minister of Health and Long-Term Care, Eric Hoskins, on how to implement Ontario's Comprehensive Mental Health and Addictions Strategy over a three-year period. The Council, made up of 20 members, listed their top priorities as:

- improving transitional supports from youth to adult services;
- creating parity between the province's mental health and addictions systems and other parts of the healthcare system;
- improving supports for Indigenous peoples, prioritizing investments towards supportive housing; and
- the need to ensure a single provincial ministry was handling youth addictions policy and programming (Government of Ontario, 2014b).

The priorities of the Council were important as there were clear ideas on the continuing importance of youth and mental healthcare in the province, but also in ensuring a transition into adult mental healthcare services as well. This is further evidence of the shift away in

priorities from serious mental illness to less acute and more treatable illnesses and on an expansion of that focus to the population at large.

The following month, in December 2014, the Minister of Health and Long-Term Care, Dr. Eric Hoskins, along with the Minister of Children and Youth Services, Tracy MacCharles introduced the second phase of the 2011 Open Minds, Healthy Minds report. This report outlined the government's commitment to continue to invest and transform mental health and addictions supports throughout the province. However, at this time, the priority population had expanded to include adults as the natural next step.[38] The 2014 report outlined five foundational pillars (Government of Ontario, 2014b):

1. Promoting Mental Health and Well-Being
2. Ensuring Early Identification and Intervention
3. Expanding Housing, Employment Supports and Diversion and Transitions from the Justice System
4. Providing the Right Care, at the Right Time, in the Right Place
5. Funding Based on Need and Quality

It was clear that while the initial phase of the 2011 report had focused solely on children and youth, the second phase of the report from 2014, focused on:

(a) continuing on the successes of Phase 1 over the remaining six years,
(b) expanding the transition supports into adult mental healthcare services, as well as
(c) improving the quality of services overall.

In addition to the transition supports for youth moving into adulthood, there was also a reinforcement in the second phase of the strategic plan to increase supports for adults suffering with mental health and addictions issues.

The 2014 report also highlighted the progress achieved from the initial report in 2011. It noted that over the previous three years, improvements in children and youth mental health had been made, such as (Government of Ontario, 2014b):

- the Ontario youth suicide prevention plan;

[38] ON11 (Ministry of Health), interviewed by the author, May 3, 2022.

- increased psychiatric consultations for children and youth through expanded and enhanced Tele-Mental Health services; and
- over 50 000 additional children and youth receiving mental health supports.

Thus, the report demonstrated that there had been a shift in priorities of illness, with a strong provincial focus on preventive mental health measures as opposed to solely only crisis mental health supports, which had been the case historically for the Canadian mental healthcare system. It also firmly opened the door to alternative forms of mental health treatment and treatment providers by concretizing the shift from institutional care associated with the purely medical model and establishing the foundations for treatment in community-based care.

An important development and a further reflection of the shifting priorities on illness, treatments and treatment providers took place beginning in May 2015 with the first delivery of CBT-based treatments to provide psychological support to patients and to be possibly delivered by non-medical service providers. Coinciding with the government's aim at expanding mental health care for depression and anxiety to adult populations, CMHA York and South Simcoe region initiated a two-year pilot project, from May 2015-December 2017, trialing Bounce Back and its suitability for Ontario. They surveyed 119 participants and received positive feedback on its results: 92% would recommend the program to a friend or family member; 94% found the workbooks easy to read and helpful; and 95% enjoyed the telephone service (CMHA Ontario, 2018: 9). The CEO of CMHA York and South Simcoe region, Rebecca Shields, who had previously served as the Executive Director at the CMHA BC Vancouver Burnaby Branch, had advanced the idea to the Local Health Integration Network Home and Community Care Support Services (LHIN) of bringing Bounce Back to Ontario.[39]

> "I think in terms of when Bounce Back was brought it had to do more with Rebecca – I think the timing, again this is preceding me – the program got originated in BC in 2008 and what I understand is that she was in BC at the time and when she came back to CMHA York and South Simcoe Region, she had already been familiar with the program and brought it here."[40]

[39] Steve Lurie (former Executive Director of CMHA Toronto), interviewed by the author, March 18, 2022.; ON3 (CMHA Senior Director at CHMA York Region), interviewed by the author, April 1, 2022.
[40] ON5 (CMHA Ontario OSP Lead), interviewed by the author, April 12, 2022.

Bounce Back would eventually form the basis of the low-intensity part of the stepped-care model for the Ontario Structured Psychotherapy (OSP) program. While Shields' previous knowledge and firsthand expertise with the roll-out of the program allowed her to make a strong case for the trial, there was also a bit of fortuity "due to the timing" and "a bit of luck" in those things had aligned and worked out this time.[41]

In keeping with the successful approach in British Columbia, the framing of Shields' pitch to the LHIN focused on Bounce Back as a broader remedy to several priorities in the healthcare system; not just as a treatment for depression and anxiety but was also aimed as a solution for chronic disease management (I.e. diabetes, congestive heart failure etc.) – which was a high priority for the province, at the time. While there was no direct evidence from public documents or interviewees alike linking the trial to the eventual adoption of Bounce Back within the OSP program, there was a high likelihood that the Ministry of Health would have been informed by the LHINs (who Shields had pitched the program to) about the success of the program. As with BC, the program was viewed and Shields had learned from her role in BC at the time the *Bounce Back* program was created and implemented, that it needed to be introduced and sold as a supportive program that was primarily intended to help primary care physicians provide support to patients dealing with mild to moderate forms of depression and anxiety. It was also viewed as an alternative to pharmacological based treatments alone and addressed the same problem of the lack of access that existed in BC.

> "In particular in BC, it [Bounce Back] was directly to help primary care physicians where they were experiencing depending on the physician 40 to 60 percent of their patients coming in with these types of issues and having no service options other than medication to treat them that were publicly funded in British Columbia – which is similar here."[42]

In addition to the Bounce Back trial, several other developments took place in in 2015 that pushed the intertwined and evolving ideas and priorities of mental health illnesses, treatments and treatment providers into a more open policy space, including many mental health reforms and priorities that took place within the province. First, there was the further

[41] Rebecca Shields (CEO, CMHA York Region & South Simcoe), interviewed by the author, April 6, 2022.
[42] ON5 (CMHA Ontario OSP Lead), interviewed by the author, April 12, 2022.

professionalization of psychological care in the province when, on April 1, 2015, the *Psychotherapy Act, 2007* was proclaimed into law and eventually coming into force on December 30, 2017. The Act, a response in 2007 to the increasing public safety risk potential associated with the unlicensed practices of mental health care, included provisions that authorized members of six professional colleges to perform the controlled act of psychotherapy and in compliance with the provisions of the various acts, regulations and by-laws that govern each of their professions (CRPO, n.d.). The six colleges included the following members:

- College of Registered Psychotherapists of Ontario;
- College of Psychologists of Ontario;
- Ontario College of Social Workers and Social Service Workers;
- College of Nurses of Ontario;
- College of Occupational Therapists of Ontario; and
- College of Physicians and Surgeons of Ontario

The proclamation included an amendment that provided for a two-year transition period, ending December 31, 2019, that would enable the newly designated professionals time to register with the appropriate colleges or the opportunity to change their practices so that they were not at risk of violating the controlled act of psychotherapy. It was clearly noted that by the end of the two-year transition period, anyone performing the controlled act of psychotherapy *had* to be registered within one of the six colleges (CRPO, n.d.). This was significant for the field of psychotherapy as well as its providers for two reasons. First, it greatly expanded the range and quantity of mental health treatment and service providers. Second, from an ideational or constitutive perspective, it demonstrated the province's commitment and recognition of the field of psychology as one that required training, expertise and qualifications on par with those within the medical field as well as recognition of it being a multi-profession-based treatment option.[43]

[43] As of January 1, 2020, only regulated professionals are authorized to perform the controlled act of psychotherapy. Based on the *Regulated Health Professions Act, 1991,* 14 controlled acts are set out as inherently risk and should, therefore, be only performed by qualified professionals to ensure client and patient safety. Controlled psychotherapy is defined as "Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning (CRPO, 2020)."

A second key development and that further built on the province's momentum in addressing children and youth mental health treatment and service needs, *Bounce Back*, which was aimed towards the ages of 15 and over, was adopted on a province-wide basis in December (CMHA Ontario, 2015b). As was the case in the UK and BC, the low-intensity program aimed to provide free virtual mental health services through workbooks and video calls to help address low to moderate forms of anxiety and depression. Following the successful two-year long pilot project by the CMHA York and South Simcoe in 2017, under the leadership of CEO Rebecca Shields, the Bounce Back program was expanded across the whole of the province and was freely accessible to all citizens, including youth and adults (Schumann et al., 2024).

A third key development during this period was that the ideational contest around mental health treatment and services had also gained greater public attention at this time. For example, a series of articles and commentaries regarding the benefits of a publicly funded psychotherapy program were shared across Canada and thereby raising the profile of the arguments in favour of different priorities, treatments and treatment providers. One article, published in May 2015 in the Globe and Mail by Erin Anderssen made "The case for publicly funded therapy". In it, mental health leaders, such as Dr. Paul Kurdyak, a Toronto-based psychiatrist at CAMH at the time, argued that research showed that psychotherapy could be as effective as medication in battling less serious forms of mental illnesses and concerns and that it was "baffling" that despite the evidence, the province was not following it (Anderssen, 2015). Whereas mental health had traditionally been a space for physicians and the medical model, this was also evidence of allyship and the continuing recognition of the need for different types of treatments from those in the medical profession.

On December 16, 2015, the Mental Health and Addictions Leadership Advisory Council released their first report called *Better Mental Health Means Better Health* and which outlined five key priorities (CMHA Ontario, 2015a; Government of Ontario, 2015):

- improving transitioning supports from youth to adult mental health;
- creating parity between the province's mental health and addictions systems and other parts of the healthcare system;
- improving supports for Indigenous peoples;

- prioritizing investments in supportive housing; and
- ensuring a single provincial ministry was responsible for youth addictions policy and programming.

This Council report adhered to the objectives from the provincial reports from 2011, *Open Minds, Healthy Minds*.

A second annual report was also released by the Ministry of Health and Long-Term Care in 2016 and which coincided with the announcement of $140M investment towards mental health and addictions over the next three years. This second report focused on three strategic considerations:

- to promote, prevent and intervene early;
- close critical service gaps; and
- to build foundations for system foundations.

These considerations led the Council to make three key recommendations to the Ministry of Health and Long-Term Care (Government of Ontario, 2016):

- First, to work collaboratively with other ministries and stakeholders to promote, prevent, and intervene in mental health concerns early and across the lifespan. This report noted the wider impact that enhanced mental health supports would have. For example, they mentioned that investments in mental health spending would have the highest returns on (in terms of cost savings) in the education, justice, and healthcare sectors.
- Second, they recommended closing critical and chronic service gaps in three different areas: youth addictions, structured psychotherapy, and supportive housing. The Council highlighted the current gaps in service capacity for youth addictions, in addition to establishing service standards and referral pathways for psychotherapy services. Finally, undertaking steps towards a large-scale system transformation by leveraging and building on the work of the Ministry of Children and Youth Services to achieve a seamless transition for children and youth to the adult system.

The second recommendation to address core and critical gaps in service provision specifically called for piloting:

> … evidence-based self directed and individual/group and cultural psychotherapy models, including those targeted and/or tailored to populations at-risk, and identify the most effective, integrated models to scale up access to structured psychotherapy (Government of Ontario, 2016, page 7).

As part of the third system transformation recommendation, the report called for the province to:

> Adopt a set of core mental health and addictions services across Ontario that have dedicated funding support, are available to all Ontarians, and are accessible in all regions of the province (Government of Ontario, 2016, page 12).

While the report did not specifically call for the introduction of a stepped or varying degrees of intensity CBT program, it did highlight structured psychotherapy services as a core element and recommend that "[c]ounselling and therapy services focus on reducing the severity of and/or remedying the emotional, social, behavioral and self-regulation problems of individual" (Government of Ontario, 2016, 13).

The 2011 report of the Standing Committee of the Ontario Legislature and the continuing and high-profile work (within the government) by the Mental Health & Addictions Leadership Advisory Council were instrumental in continuing the legitimation of psychotherapy as an alternate and appropriate form of treatment and contributed to the province's decision to adopt a publicly funded psychotherapy program to Ontario.

> "I wonder if the impetus was recommendations made by the provincial Mental Health and Addictions Leadership Advisory council and they did a report – it was their second annual report called *Moving Forward: Better Mental Health Means Better Health* and the council was formed in 2014 and it included different representation from different sectors as well as those with lived experiences and so it was probably their recommendation for structured psychotherapy – you know to pilot evidence-based, self-directed individual psychotherapies and scaling it up. And I think that came in 2014, so maybe that was what drove a lot of this to happen."[44]

Coinciding with this activity was the continuing work of interested actors and the ongoing relationship-building in the mental health policy space. Bob Bell, the Deputy Minister of Health,

[44] ON5 (CMHA Ontario OSP Lead), interviewed by the author, April 12, 2022.

and Dr. Catherine Zahn, CEO of the Centre for Addictions and Mental Health (CAMH) and one of the Mental Health and Addictions Advisory Council members, had been close colleagues from the time they had worked together at the University Network Hospital. Zahn, a well-known advocate for publicly funded psychotherapy, publicly pushed for its greater incorporation into existing mental health treatment and services. For example, she stated at the Economic Club of Canada luncheon in Ottawa in October 2016:

> "How could we have ended up with a publicly funded healthcare system that doesn't cover effective interventions for mental disorders – when we hold mental health as central to all health? (CAMH, 2016)."

As identified by a number of policy actors in the mental health policy space in Ontario, the close working relationship between Zahn and Bell and their shared advocacy for a broader approach to mental health priorities, treatments and treatment providers was instrumental in the adoption of the province wide psychotherapy program:

> "Catherine Zahn and Robert Bell – they were colleagues at the time Bob was Deputy Minister of Ministry of Health and Long-Term Care and were able to build a wonderful working relationship. Later on, Catherine became CEO/President of CAMH."[45]

> " I think there was some big players in the Government's Mental Health and Addictions Advisory Council, so it was like people like…Catherine Zahn, Camille Quenneville, Adrienne Spatford – all the heavy hitters in mental health and I think they were wanting publicly-funded psychotherapy (that's something they've been heavily advocating for a long time) as a part of a core service system and so I think they pushed hard to advance that…and probably the four implementing pilot sites were probably all at that advisory table. I imagine that had something to do with that."[46]

Relationships and the role of key policy actors was important for not only highlighting the importance of talk-based psychotherapy as a legitimate, if not essential treatment for lower-end mental illnesses, but also ultimately in the shape of what those services and treatments would

[45] Steve Lurie (former Executive Director of CMHA Toronto), interviewed by the author, March 18, 2022.

[46] ON8 (Senior Director at CAMH), interviewed by the author, April 21, 2022.

look like. David Clark, one of the two policy entrepreneurs from the UK's nationwide program, Talking Therapies (formerly known as IAPT) and a key source of advice in British Columbia's introduction of Bounce Back, also came "at least half a dozen times" to Ontario prior to the adoption of the OSP program and had multiple visits with Dr. Robert Bell and his team at the Ministry of Health during his tenure. Additionally, well-known academic psychiatrists in Ontario at CAMH, Drs. David Goldbloom and David Gratzer also noted building a wonderful working relationship with David Clark as well. Dr. David Gratzer, a psychiatrist at CAMH shared:

> "Clark has spent a lot of time here in Ontario. I've known Clark for a while, and I have seen him speak in Ontario half a dozen times. But if you're a policymaker in Ontario and you're keen on this, you probably have spoken to Clark."[47]

In this case, the development of strong personal relationships with healthcare leaders in Ontario and David Clark potentially made for a stronger case in the province adopting the UK's Talking Therapies model:

> "We had significant connections with the Chief of Psychiatry at the South London, Maudsley Hospital at King's College, and Oxford – there were a lot of connections. I mean this is a characteristic of Ontario healthcare that the generation before me and probably the generation before that had very close ties in the neuroscience world and in the psychiatric world to London, England. And so, that simply was habit and has carried on – I think it's nothing more exotic than that. I don't think people did a widespread search of the good literature – except maybe to look at the US and say: "We're not going to do that. But it was very much that Ontario and Toronto is London influenced."[48]

The existing relationships and prior practices seemed to be a key factor in pursuing the expanded publicly funded psychotherapy program, rather than research or advice coming from a "cross-jurisdictional scan" or "looking at best practices". Instead, Zahn indicated that Ontario had historically always had strong ties with the UK when it came to the consideration of policies and programs aimed at treating mental health. Thus, it was not a coincidence or surprise that

[47] David Gratzer, interviewed by the author, July 7th, 2022.

[48] Dr. Catherine Zahn, interviewed by the author, April 19, 2023.

the province was easily persuaded to follow the UK model.[49] In short, when seeking to address the mental health illness priority associated with depression and anxiety and with evolving approaches to treatment and treatment providers, Ontario policy-makers learned about and preferred to adopt the UK model of a mixed intensity CBT approach that represented a larger program than the one implemented in BC.

The Ontario Publicly-Funded Psychotherapy (OSP) Program

Following off the second report of the Mental Health and Addictions Advisory Council in 2016, the government announced in February 2017 that it would allocate a modest sum of $140M over a three-year period towards mental health and addictions services, including psychotherapy and supportive housing.

Confirmation and legitimization of the province's approach and its pilot project was provided in June 2017, when the Mental Health Commission of Canada (MHCC) released a report entitled *Options for improving access to counseling, psychotherapy and psychological services for mental health problems and illnesses* (MHCC, 2017). Financial support from the federal government to the provinces to address mental health systems across the country soon followed. In August 2017, the Government of Canada confirmed that there would be a new Canada Health Accord, including a $5B investment over the ten years to the provinces and territories for increased access to mental healthcare services. This $500 million per year (on average) targeted funding was considered an historic step in closing the estimated $3.1B annual gap in mental healthcare.

More importantly, the federal government's funding announcement served as a catalyst or *window of opportunity* for mental health advocates, such as Drs. Robert Bell and Catherine Zahn, who were in favour of a publicly funded psychotherapy in Ontario. This announcement essentially provided "money that [they] were aware was coming in and had to be spent [towards mental healthcare]."[50] As the policy entrepreneur literature suggests, entrepreneurs often take advantage of short windows of opportunities to push their ideas to achieve policy

[49] Ibid.

[50] Dr. Bob Bell (former Deputy Minister of Ministry of Health and Long-Term Care & Surgeon), interviewed by the author, March 30, 2022.

change, in which case, Bell and Zahn took on such roles in this case to adopt a province-wide psychotherapy program.

In October 2017, and shortly after the federal announcement regarding the targeted mental health funding, the Ontario government, as it had promised in February, announced it would allocate $72.6M towards the launch of a three-year pilot project (2017-2020) for a province-wide publicly funded psychotherapy program. Considered a first-of-its kind in Canada, Ontario introduced a province-wide, structured, publicly funded psychotherapy program that would be developed in collaboration with mental health experts, service providers, and people with lived-experiences. This new program would make Ontario the first province in Canada to provide a stepped-care program similar to that of the UK's Talking Therapies program (offering both low and high-intensity publicly-funded structured psychotherapy) to help treat those with mild to moderate forms of anxiety and depression (Government of Ontario, 2017).

The pilot project consisted of the provincial government funding three separate but interrelated programs:

- Bounce Back,
- iCBT, an online mental health self-management tool coordinated by the Ontario Telemedicine Network, and
- in-person therapy offered by the four mental health hospitals (CAMH, Ontario Shores, Waypoint, and the Royal) (Government of Ontario, 2017).

The following month, in November 2017, the Health Quality Ontario (HQO) provided a report to the Ministry of Health and Long-Term Care outlining the importance of this approach by recommending evidence-based, structured individual and group psychotherapy and that it be provided by non-physician providers that should be publicly funded for individuals with depression and anxiety disorders (Health Quality Ontario, 2017). This was evidence of changing ideas within the province of the legitimacy of the newly regulated and aligned health professionals and who could also offer mental health services, and psychotherapy in particular, beyond physicians.

The four hospitals that were the designated service providers under the final element of the pilot project also served as hubs which trained and oversaw counsellors to deliver CBT

services at dozens of community locations. The four hospitals would act as the Network Lead Organizations (NLOs) and partner with providers who were the service delivery sites (SDS) such as: community health centres (CHCs), family health teams (FHTs), community mental health agencies, colleges, and universities. While the NLOs and SDSs had been providing "high-intensity" CBT therapy, CMHA was responsible for providing "low-intensity" CBT therapy through their Bounce Back program.

Certainly, from the outside, it appeared that Ontario had made a considerable step forward in mental healthcare by being the first province in Canada to work towards increasing access to publicly-funded mental healthcare through the launch of the three-year pilot project and collaborating with local community organizations. However, the expansion of mental health treatments and services was not without contest. In fact, the development of the OSP program involved heavy tensions, particularly between the hospitals and community organizations. This was evidence of existing institutional legacies from hospitals and psychiatric institutions despite strong ideas pushing for – and achieving – policy change, which shifted mental healthcare to community-based settings. During the initial launch of the pilot project in October 2017, the Ontario Ministry of Health had decided to fund the four mental health hospitals, CAMH, Waypoint, Ontario Shores and The Royal to deliver high-intensity CBT therapy. In contrast, CMHA was responsible for the delivery of the low-intensity program, Bounce Back. Each of the four pilot hospitals were provided an amount of $5M whereas CMHA was provided only $8.9M to roll out the Bounce Back program across the whole of the province.[51] This appeared to re-emphasize the institutional model of care, despite the advantages inherent and understood in the emerging community-based approach.

> "Within Ontario, there are different power positions, powerful positions in terms of influence within government and having a large budget exists within hospitals…Why would they fund them to service people with mild to moderate forms of depression when that client population is typically better served in the population? The target population we are talking about are people like you and me. Like I recommend this program to my friends – they don't need to be in

[51] ON3 (Senior Director at CHMA York Region), interviewed by the author, April 1, 2022.

psychiatric hospitals. We have a number of capable organizations across the province who already serve this population and maybe could better serve it?"[52]

"It's really expensive to buy services from a hospital – we have to pay a lot more for them than for community organizations…so it's costing a lot…there is just that power dynamic going on."[53]

The underlying tension between them was caused by the concern that the intent of the publicly funded program was to deliver mental healthcare services for individuals with mild to moderate mental illnesses, yet the government was choosing to locate the responsibility within and to fund psychiatric hospitals at a greater level than their responsibility would suggest. This was particularly unexpected for a low-intensity CBT program such as Bounce Back, that did not need to be delivered by a physician or other medicine based mental health professional as the majority of the program is independently working through workbooks with the guidance of a Bounce Back coach over the phone.

The Conservative Government

(i) Doug Ford (2018-present)

Doug Ford's Progressive Conservative Party (CPC) won a majority government on June 7, 2018. During the election campaign and in its early days in office, the new Ford government was quite vocal regarding their intentions to internally restructure healthcare delivery in the province. Some immediate changes which took place included:

- Dr. Reuben Devlin's appointment as special advisor healthcare form, leading the new Premier's Council on Improving Healthcare and Ending Hallway Medicine;
- Re-organization of Ministry of Health:
    - Hon. Christine Elliot, remaining as Ministry of Health
    - New Minister of Long-Term Care, Hon. Merrilee Fullerton as new Minister
    - New Associate Minister of Mental Health and Addictions, Hon. Michael Tibollo

[52] ON3 (Senior Director at CMHA York Region), interviewed by the author, April 1, 2022.
[53] Ibid.

The last appointment is notable for its elevation of mental health to a full Cabinet position and the appointment of separate Minister to advance the work of mental health and addictions services within the province. It was also noted that the new Minister would work closely with the Minister of Health to address the existing gaps in Ontario's mental healthcare system (Government of Ontario, 2020). This announcement and appointment was followed by a re-structuring of the Ministry of Health through the creation of the Mental Health and Addictions Division on September 16, 2019.

Coinciding with the initial forays by the Ford government into restructuring responsibility for mental health care in the province was the continued and broader support for increasing psychotherapy in the province and across the country. In August 2018, the Mental Health Commission of Canada followed up its initial 2017 report roughly a year later with a second report, entitled *Expanding Access to Psychotherapy: Mapping Lessons Learned from Australia and the United Kingdom to the Canadian Context* (MHCC, 2018). When taken together, the two reports made the case that, after having conducted a jurisdictional scan, the MHCC had concluded that existing international models for greater delivery of psychotherapeutic care were replicable within the Canadian context. While there were differences noted between the Australian and UK models, the report concluded that there was an opportunity for provincial and territorial governments to carefully consider the two options as either would be feasible for implementation in Canada.[54] This presence of strong ideas provided opportunity for provinces and territories across Canada, including Ontario, to more fully consider the permanent adoption of a publicly funded psychotherapy program that was either modelled after the UK or Australia (Mental Health Commission of Canada, 2017).[55]

[54] The *UK's Talking Therapies* program operates a largely government-funded (grants-based), centralized program, whereas *Australia's Better Access* program is primarily insurance-based through their Medicare, which allows patients to access a wider range of healthcare providers such as psychiatrists and psychologists through their family physicians. Both models are similar in that they utilize a stepped-care approach, where individuals are likely to start with low-intensity interventions before escalating to more intensive approaches. The UK's program has a more central, tight management to standards, targets, and robust data and requires a significant workforce and allocation of administrative resources (MHCC, 2018). On the other hand, Australia's program is much more hands-off in terms of their reliance of self-regulation and administrative Medicare data that has been able to increase access across the board, but provides less quality assurance (MHCC, 2018).

While the overall ideational space was conducive to the expansion of treatments and treatment providers, the separation of mental health and addictions as separate policy concerns from the overall health portfolio provided a further and continued extension of mental health as a priority policy concern to the new Conservative government. The proclamation of the Mental Health and Addictions Centre of Excellence Act was made on February 18, 2020, and had been formally established within Ontario Health. Shortly after, on March 3, 2020, the provincial government launched its own new mental health plan, *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System,* to ensure that Ontario could provide easier access to high quality mental health care in communities across the province. Developed after consultations with hundreds of mental health and addictions organizations, frontline staff, hospitals, advocates, experts, and people with lived experiences, this mental health plan, as the name implies, was designed to serve as a guide for the province in building a comprehensive and connected mental healthcare system within the province (Government of Ontario, 2020). Built on four pillars, the Ontario Structured Psychotherapy (OSP) program is funded through the *Roadmap to Wellness strategy* and part of a key commitment in the strategy, as evidenced below (Government of Ontario, 2020):

- Improving quality
- Expanding existing services
- Implementing innovative solutions
- Improving access: a new provincial program and approach to navigation

This strategy also introduced the new regionally based Mental Health and Addictions Centre of Excellence, which would serve as the foundation of which the Roadmap to Wellness and oversee the OSP program. The Mental Health and Addictions Centre of Excellence aims to (Ontario Health, 2024):

- Provide a central point of oversight for mental health and addictions care;
- Be responsible for standardizing and monitoring the quality and delivery of evidence-based services and clinical care across the province to provide a better and more consistent patient experience; and

- Provide support and resources to Ontario Health Teams (OHTs) as they connect patients to the different type of mental health and addictions care they need and help them navigate the complex system

On June 10, 2021, Ontario Health provided an update on the Ontario Structured Psychotherapy's three-year pilot program. An update on how the program had been running since April 30, 2020, demonstrated that the four pilot sites, had enrolled 6697 clients, and boasted a 40 percent recovery rate. Bounce Back had enrolled 16 104 clients with a 41 percent recovery rate. Thus, given the promising results, the province had decided to scale up the overall program (Rossi & Martin, 2021).

In addition to the four pilot sites – CAMH, Waypoint, The Royal and Ontario Shores – Ontario Health announced on April 30, 2021, that six more sites had been added based on the recommendations of the Ministry of Health for them to serve as network lead organizations, who would work alongside community-based providers across their respective regions to support the delivery of the OSP program (Ontario Health, 2021). The new additional six Network Lead Organizations (NLGs) in addition to the original four pilot sites were:

- Canadian Mental Health Association – York Region (Ontario Health region – Central)
- CarePoint Health (Ontario Health region – Central)
- St. Joseph's Healthcare Hamilton (Ontario Health region – West)
- St. Joseph's Healthcare London (Ontario Health region – West)
- Health Sciences North (Ontario Health region – North)
- St. Joseph's Care Group, Thunder Bay (Ontario Health region – North)

These NLGs would lead the establishment of new regional networks of local community-based service providers to deliver high-quality psychotherapy to Ontarians across the province. They were selected based on their capacity to provide the clinical, fiscal, and administrative oversight necessary to expand and continue the success of the initial launch of the OSP. The continued role of these ten sites, including the four original pilot sites, was to:

- work closely with local communities to develop their regional network of engaging with local community health service provides to identify an initial group of service delivery sites within their respective region;

- implement key network infrastructure, including data-driven systems to support consistent high-quality care and a centralized intake and assessment mechanism for easy referral; and,
- develop governance, fiscal, administrative, and clinical structures to provide oversight of the performance of the network (Ontario Health, 2021).

The expansion of the OSP program was a key commitment in the province's Roadmap to Wellness which focused on improving mental health services for communities across Ontario, in addition to providing support to patients and families living with mental health and addictions challenges (Ontario Health, 2021). The OSP program is funded through the Roadmap to Wellness strategy, while the Mental Health and Addictions Centre of Excellence is responsible for supporting implementation and oversight of OSP, in collaboration with the Ministry of Health and its partners. For example, in the case of Ontario's West Region, OSP is managed through a partnership between St. Joseph's Health Care London and St. Joseph's Healthcare Hamilton, in addition to numerous community organization who deliver and provide local therapy services to individuals (St. Joseph's Healthcare Hamilton, n.d.).

Currently, the OSP program is coordinated by 10 NLGs across the province, who all work with different organizations to provide mental healthcare services. Deputy Premier and Minister of Health, Sylvia Jones stated in October 2023 that there are over 100 OSP service delivery sites across the province and range of treatment options available, which demonstrates significant growth since the initial launch of the four pilot sites in 2017 (Government of Ontario, 2023). This is evidence of the province's shift and efforts towards establishing a more extensive and integrated system for mental health treatment. Rather than relying on psychiatric institutions as they had in the past to treat mental illnesses, there is a wider range of healthcare providers and community resources to provide more comprehensive mental healthcare. To date, over 66 000 Ontarians have enrolled in the OSP program and all NLGs continue to accept new clients and initial success of the program has shown that over half of individuals have completed high-intensity treatments which have significantly reduced symptoms for depression and anxiety (Government of Ontario, 2023).

Conclusion

Ontario was the first province in Canada to introduce a publicly funded and more fully intensive mental health program aimed at the broader general public, including both youth and adults, and that would serve to address the mental health crisis in the province associated with less acute mental illnesses, such as depression and anxiety. Learning about and borrowing from both the UK and BC, Ontario incorporated the Bounce Back program, involving minimal treatment services and was a mostly self-directed cognitive behavioural therapy program, into its mental health policy regime and coupled it with more intensive therapy programs as contained in the UK model. In this regard, Ontario represents a slow and big policy adoption approach, having taken a full ten-years before piloting OSP in the province and another three years before its full adoption. A tracing of the timelines associated with the evolution, development and adoption of the OSP in Ontario demonstrates evidence of some involvement of each of the four theoretical explanations in helping understand the policy change that took place in Ontario.

i. Ideas

As in British Columbia, the influence of ideas on the mental health policy space occurred at three interconnected levels of:

a. Type or Priorities of Mental Illness,
b. Appropriate Types of Treatments, and
c. Appropriate Treatment Providers

Like the rest of Canada, Ontario had largely focused on serious or severe mental illnesses until the mid-2000s when the broader policy agenda, led by the federal government and the publication of the Kirby report, shifted focus to less severe forms of mental illness and a greater commitment to mental health, and more specifically, community-based mental healthcare. While the 1988 Graham Report had previously made the case for the province to expand access to community-based mental health treatments, that report clearly continued to focus on and recommend that priority be given to those with severe or serious mental health illnesses. The cost cutting focus of successive governments of differing political stripes did little to change that

focus. With the Kirby report and the McGuinty government's overall commitment to children, there was an increased understanding the economical and health-outcome benefits of preventive mental healthcare, including a focus on children and youth mental healthcare services.

Coinciding with the evolving understanding of less severe forms of mental illness as a priority in the mental health space, the ideas associated with community based mental health care also became more clear and less contested in the province. These alternate forms of treatment and treatment providers become both professionalized and more fully recognized and supported with the passage of the Psychotherapy Act, 2007 and as a means of mitigating risks to the public. These changes, occurring at the same time as the evolving focus on less severe mental illnesses provided a more conducive environment for the incorporation of alternate therapies and non-medical and allied mental health therapy service providers beyond psychiatric and pharmaceutical interventions and services associated with a more pure medical model of health care provision.

ii. Institutions

It is evident that despite the success in adopting a province-wide and more intensive psychotherapy program, policy legacies within the Ontario's healthcare system, particularly within mental health exist and continued to influence the design and implementation of the new overall program scheme. These legacies were established early on with the introduction of psychiatric hospitals in the 1850s and later in the 1960s through the introduction of public health insurance (Mulvale et al., 2007). This granted physicians, particularly those who deliver mental healthcare services such as psychotherapy, such as family physicians and psychiatrists, with special privileges, such as financial benefits (i.e. covered under public health insurance) and access to decision-making authority, as well as access to policymakers through their respective medical associations to block policy changes that placed them at a disadvantage (Mulvale et al., 2007). On the other hand, allied mental health professionals such as psychologists, social workers, and occupational therapist etc., who are not covered through

hospital insurance, found themselves working outside of the public healthcare system in private practice and which did not privilege or protect their interests (Mulvale et al., 2007).

This continuing legacy of the prioritization of mental health hospitals, and the tensions in the broader policy network, evidently exist on an ongoing basis. When funds were distributed for the pilot sites of the publicly funded psychotherapy program (OSP) in Ontario, there were tensions between the non-profit mental health organization, CMHA Ontario, and the four pilot mental health hospitals (CAMH, Waypoint, Ontario Shores and The Royal), with the latter four receiving a disproportionate share of funding and responsibility. As one interviewee so acutely stated,

> "This is a mental health service for those with mild to moderate mental health concerns such as anxiety and depression, why do they need to be provided in a hospital-based setting, when such services are much more costly than those delivered in a community-based setting?"[56]

iii. Policy Entrepreneurs

Perhaps the easiest way to identify key policy entrepreneurs is by relying on who was identified as such by policy actors in a given policy space. As a number of interviewees from Ontario shared, there were two influential physicians who took on the role of what some might refer to as policy entrepreneurs, Drs. Catherine Zahn and Robert (Bob) Bell. The duo had a wonderful working relationship prior to the collaborative work that eventually led to the adoption of Canada's first publicly funded psychotherapy program. During the time Bell was Deputy Minister of Health, Zahn was CEO of Canada's top mental health hospital, CAMH, which meant that they both had the status and prestige within their respective careers, as well as a wide network of individuals both within and outside of government. Leveraging both of their respective positions and networks, they were able to advocate and make a strong case for why the province would benefit by adopting a province-wide publicly funded psychotherapy program, like the UK and Australia.

[56] ON3, interviewed by the author, April 1, 2022.

Ontario was also unique in that while there were expectations that physicians would not be supportive of a program that delegated healthcare services to non-physician providers, influential physicians at CAMH in addition to Bell and Zahn were also advocating for such a program. In addition, academic psychiatrists from CAMH, such as Drs. David Goldbloom and David Gratzer, were actively publishing in academic journals and op-eds of the benefits of adopting the UK model in Ontario. They had developed a close working relationship with one of the two entrepreneurs of the UK program, David Clark and had met at various times throughout the years. Clark had also been invited by Bell and Zahn on a couple different occasions to present the UK case on publicly funded psychotherapy as well, which meant that there were close and friendly ties with the UK, which in turn would have made adopting a program that UK-inspired as opposed to the Australia model, much more likely.

Finally, Rebecca Shields brough her experiences and the Bounce Back program from British Columbia to Ontario and trialed it to great success at CMHA York and South Simcoe. The initial results of the program following its limited introduction into the province were clear and unequivocal successes and would not have gone without notice by the Ministry of Health.

iv. Policy Learning

In terms of policy learning, there is also strong evidence that this occurred in Ontario, from both within and outside of the country. In the case of the Bounce Back program, which makes up the low-intensity element of the Ontario Structured Psychotherapy (OSP) program, it was inspired by the program that was first adopted from the UK under the leadership of Dr. Christopher Williams, and then modified by CMHA-BC and trialed in Ontario by Rebecca Shields (and based on her experiences of what worked in BC). On the other hand, the general stepped-care model that OSP is based on, which includes a mixture of both low and high-intensity CBT treatments was inspired by the UK's nationwide, publicly funded *Talking Therapies* program, which was first adopted in the 2008. Provinces across Canada, including Ontario, quickly learned from knowledge and information-sharing that if Canada wanted to adopt a publicly funded psychotherapy program, there were two international jurisdictions that they could look to: UK,

through their Talk Therapies programme, or alternatively, Australia, with their Better Access program, thus, it was expected that Ontario would choose between the two jurisdictions.

Finally, an important aspect of the learning which occurred in Ontario in addition to the emulation of the UK stepped-care model was that of the importance and value of non-physician providers in the delivery of mental healthcare, or more specifically, psychotherapy. A large selling point of the UK's Talking Therapy program was that treatments did not have to be provided by physicians but also allied mental health professionals such as psychologists, social workers, counsellors etc., to deliver the high-intensity services, which involve face-to-face psychological therapy sessions.

As is in British Columbia, there is clear evidence of the different theoretical explanations at play that help to understand the initial policy stability in Ontario and the subsequent much larger and later policy change – that as the ideas associated with mental health, mental health treatments and mental health treatment providers were in flux and less widely contested, there was space for specific and well-placed policy entrepreneurs who had learned from other efforts to address a similar policy problem to provide advice to government, albeit constrained to some extent by existing policy legacies.

Appendix

The 20 members of the Mental Health and Addictions Advisory Council were as follows :

- Susan Pigott - Chair of Ontario's Mental Health and Addictions Leadership Advisory Council; has previously held senior positions with the Centre for Addiction and Mental Health and St. Christopher House
- Pat Capponi - Psychiatric survivor with lived experience of poverty; part-time member, Consent and Capacity Board
- Gail Czukar - CEO, Addictions and Mental Health Ontario
- Dr. Suzanne Filion - Director, Strategic Initiatives, Mental Health and Addictions, Hawkesbury & District General Hospital
- Arthur Gallant - Mental health advocate
- Carol Hopkins- Executive Director, National Native Addictions Partnership Foundation
- Mae Katt - Nurse Practitioner
- Dr. Kwame McKenzie - CEO, Wellesley Institute
- Dr. Ian Manion - CEO, Provincial Centre for Excellence for Child and Youth Mental Health, Children's Hospital of Eastern Ontario
- Louise Paquette - CEO, North East Local Health Integration Network (LHIN)
- Camille Quenneville - CEO, Canadian Mental Health Association - Ontario
- Dr. William Reichman - President and CEO, Baycrest
- Aseefa Sarang - Executive Director, Across Boundaries: An Ethnoracial Mental Health Centre
- Dr. Kathy Short - Mental Health ASSIST lead, Hamilton-Wentworth Board of Education
- Peter Sloly - Deputy Chief, Community Safety Command, Toronto Police Services
- Adelina Urbanski - Commissioner, Community and Health Services, Regional Municipality of York

- Victor Willis - Executive Director, Parkdale Activity and Recreation Centre
- Eric Windeler - Founder and Executive Director, Jack.org
- Dr. Catherine Zahn, CEO, Centre for Addiction and Mental Health

Chapter 6: Conclusion

Introduction

The history of mental health treatments and service in Canada, like many other jurisdictions, is one of a constantly evolving policy space, particularly as understandings of mental health and illness transform with greater knowledge and rigorous research (Manderscheid et al., 2009). Historically, the understandings of mental health placed a greater focus on more severe forms of mental illnesses which corresponded with treatment in the form of institutionalization. Much of the efforts of addressing the mental health crisis at the time placed a large focus on isolating individuals within the psychiatric system and the rest of the society (Sussman, 2017). Evidently, this approach reflected significant shortcomings in health policy failure as it lacked appropriate and evidence-based treatments, was poorly regulated, and ultimately led to inhumane conditions for those receiving care within the system.

These developments also highlight some of the interlocking *ideas* associated with the scope of the mental health policy space, including:

a) An understanding the nature, severity and priority of various mental illnesses;
b) How mental illness should be treated – what are the appropriate forms and types of treatments, and
c) Which treatment and service providers are appropriate to deliver mental health care.

The understanding of what mental illness was, how to treat it and who was considered capable and qualified of providing those treatments and services were historical vastly different from those that prevail today. Beginning in the mid-1960s, governments in Canada and other jurisdictions began moving away from isolation and institutionalization of the mentally ill and sought to increase access to community-based care and supports (Sealy & Whitehead, 2004; Sussman, 2017). As understandings of the nature of mental illnesses evolved, coinciding with the deinstitutionalization movement, so did the types of mental health treatment, services, and their impacts on society. As the deinstitutionalization movement gained further momentum and became more widespread across numerous jurisdictions, this simultaneously directed attention away from severe and traditionally less prevalent illnesses and onto more widespread, albeit lower priority mental health challenges, such as depression and anxiety. These less severe forms

of mental health illness eventually became a key focus of mental health policy in the early to mid-2000s for jurisdictions such as Canada, the United Kingdom and Australia (Mental Health Commission of Canada, 2017). At the same time that priorities began to shift in the focus on less severe mental health illnesses, community-based treatments provided to more severe illnesses also became understood to be effective forms of treatment for mild to moderate forms of mental illnesses, such as depression and anxiety (Buechner et al., 2023). These developments opened up the potential for a range of new or different mental health care service providers to play a greater role in the provision of care.

While these shifts in ideas and understandings of mental health and illness along with the corresponding consideration of the relevant and appropriate forms of treatment and services and service providers was a step in the right direction for the mental health space, difficulties from the deinstitutionalization era continued to act as barriers, including the prevailing focus on patients suffering from severe forms of mental illness. In addition, the increased scope of understanding of mental health and treatments also still faced challenges due to inadequate funding and resource allocation by governments across the country and a lack of appropriate treatment providers. These ongoing pressures eventually culminated in the investigation and release of Canada's first ever national mental health report entitled *Out of the Shadows at Last* in May 2006 by the Senate Standing Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby. The Kirby report was instrumental in pushing mental health onto the political agendas of provinces and territories across the country, particularly in relation to the need for governments to address the evolving and highly prevalent depression and anxiety crisis.

Despite the increasing momentum, attention and a corresponding commitment by the federal government through the 2006 Senate Report and the development of the Mental Health Commission of Canada in 2007 to the mental healthcare crisis, the response of provincial and territorial governments differed across the country and from one jurisdiction to the next, both in timing and in scope. British Columbia was the earliest adopter and went on to adopt a low-intensity cognitive behavioural therapy (CBT) based program in 2008, *Bounce Back*. In contrast, Ontario moved nearly a decade later, albeit incrementally and with a more large-scale, provincially funded, mental health pilot program in 2017, and which included both low and

high-intensity CBT program services. In short, one province moved much more quickly in its policy and limited response (rapid timing) while the other adopted a much more comprehensive treatment approach (broader scope) at a much later date. These developments provide a useful comparison in exploring the conditions under which policy change takes place, particularly in relation to the potentially overlapping roles that ideas, institutions, policy learning and policy entrepreneurship play in leading to that change. Accordingly, this dissertation has sought to understand and explore this puzzle of policy change in relation to differences in timing and scope by aiming to answer **two empirical research questions:**

1. What conditions allowed BC to develop an early, low-intensity program and then constrained it from adopting a larger-scale program? Or, in other words, why did policy change in BC happen fast and small?
2. What conditions limited early policy development in Ontario, but allowed for a more ambitious and larger-scale program more recently? Why did policy change in Ontario happen slow and big?

In examining these two inter-related but contrasting case studies on the timing and scope of policy change in the mental health policy space, further insight was also gained concerning the policy making process in Canada and policy change factors more generally. I argue that BC quickly adopted the new policy agenda driven by a shifting idea of priorities in mental health care, and as emblematized in the Kirby report, but the scope of its ambition was constrained by a combination of four key factors:

a. Ideas on Mental Health
    i. The shift in mental health policy priorities away from depression and anxiety and towards addiction as driven by the evolving opioid crisis in British Columbia; and
    ii. Continued contestation over the appropriate forms of mental health treatment and services and, more importantly, the relevant and appropriate treatment providers;
b. Institutions
    i. Desire to maintain the status quo on the delivery of mental health programs i.e. regulating non-mental health professionals such as clinical counsellors;

ii. Lack of solidarity among medical and non-medical mental health professionals regarding who *can* and *should* provide mental healthcare services such as psychotherapy

c. Learning
    i. Early decisions made by adopting a smaller-scale CBT-based program, Bounce Back in 2008, which was also when the UK's nationwide program, Talking Therapies program was adopted, which allowed for insufficient learning;
    ii. Later, relevant actors in the mental health space in BC demonstrated negative learning in that they developed skepticism towards the UK's nationwide program, arguing that their smaller-scale program, Bounce Back was more cost-effective and produced better mental health outcomes

d. Policy Entrepreneurs
    i. The lack of successful advocacy in favour of an expanded scope of mental health treatment, including the absence of key or well-placed policy actors in the BC mental health policy space;

In contrast, Ontario may have proceeded more slowly and incrementally in adopting its policy response to the changing ideational mental health care policy environment, but four interrelated factors led to a more ambitious policy change:

a. Ideas
    i. Greater stability in the prioritization of mental illness concerns
    ii. Broader acceptance of different service providers in the mental health treatment space, as reflected in the adoption of the *Psychotherapy Act* provisions;

b. Institutions
    i. Wider acceptance among healthcare leaders, specifically those who were prominent physicians, who were supportive and advocates of the adoption of a publicly funded psychotherapy program that did not have to be delivered by physicians and/or a PhD-level Clinical Psychologists;

c. Learning
    i. Policy learning at key government levels provided by access to specialists in the UK;
    ii. Learning and experimentation at the local level and based on experiences in BC with Bounce Back, and
d. Policy Entrepreneurs
    i. Important advocacy by key policy entrepreneurs at the provincial and local levels in Ontario.

The remainder of this chapter draws together these findings and considers their impact on our understanding of policy making more generally. It is divided as follows. It reviews the findings of each of the two cases and evaluates them against the theoretical expectations by highlighting the key developments from both BC and Ontario following the publication of the 2006 Kirby report up and until the adoption of the OSP program in Ontario in 2021 (after its successful three year-long pilot from 2017-2020). It focuses on the changing nature of the ideas associated with mental health in terms of:

a. the nature and priority of illnesses
b. the appropriate and relevant treatments and services; and
c. the corresponding treatment and service providers (the "solutions") and the activity undertaken in each jurisdiction (the "actors/entrepreneurs").

The tracing and timing of these evolving ideas are set out in Table 1. It follows this consideration of ideas by examining the institutional factors at play in each case study, followed by a consideration of policy learning and concluding with an assessment of policy entrepreneurship in each jurisdiction. The chapter concludes with consideration of future avenues of research in the mental health policy space.

Table 1 – Timeline of the Evolution of Mental Health Ideas

Timeline	Priorities		Type of Service		Service Providers	
	ON	**BC**	**ON**	**BC**	**ON**	**BC**
1960s	Ontario starts their de-institutionalization process begins.	Mental health is focused on severe illnesses.	- Psychiatry - Psychology	- Psychiatry - Psychology	- Physicians - Nurses	-Physicians - Nurses
1970s		BC starts their de-institutionalization process.	- Psychiatry - Psychology	- Psychiatry - Psychology		
1980s	Ontario releases the Graham Report (1988) which prioritises individuals with serious mental illnesses & disabilities.					
1990s		Process of deinstitutionalization.	- Psychiatry - Psychology	- Psychiatry - Psychology	- Physicians - Nurses	-Physicians - Nurses
2000		2000: Establishment of Mental Health Advisory Council which consisted of services users and their families.	- Psychiatry - Psychology	- Psychiatry - Psychology	-Physicians - Nurses	-Physicians - Nurses
2007	Government introduces legislation to enable the regulation of psychotherapy and **added** the "controlled act of psychotherapy" under the RHPA.	Utendale Case is taken to court and it is determined that anyone can refer to themselves as a "psychotherapist."				
2008			- Psychiatry - Psychology - Bounce Back coaches	Adoption of the Bounce Back Program		
2015	• Government proclaimed into force the provisions of the Psychotherapy Act which created the College of Registered Psychotherapists of Ontario (CRPO). • Evidence of wide acceptance of the benefits of a publicly funded psychotherapy	BC sees a dramatic rise in opioid-related overdoses and deaths in the mid-2015s.	- Psychiatry - Psychologist - Social workers - Occupational therapists - Psychotherapists - Bounce Back as a pilot project in Ontario (2015-2017)		Psychotherapy is regulated health profession.	- Physicians - Nurses - Non-medical professionals (i.e. social workers, occupational therapists)

	program among top government and health officials.					
2016		BC declares the opioid crisis a state of emergency.				
2017-2020	Mental Health Commission of Canada (MHCC) releases reports on looking to the UK and Australia for psychotherapy programs. Ontario opts to adopt the UK model.		- Pilot Project of OSP at the four hospitals (CAMH, Waypoint, The Royal and Ontario Shores) - Bounce Back is adopted in Ontario			
2020	Expanding access to community-based programs offered by clinical counsellors (who are unregulated).	In March 2020, BC becomes the first jurisdiction globally to launch a province-wide Safer Opioid Supply policy.				
2021			OSP becomes a full-fledged program.			

Factual Findings and Theoretical Expectations

(i) Ideas About Mental Health

Ideas are defined as "causal beliefs held by individuals or adopted by institutions that influence their attitudes and actions" (Beland & Cox, 2010). The existing literature suggests contrasting impacts of the role of ideas, in which they can act as a driver for achieving policy change, but at the same time also inhibit or obstruct alterations of the policy status quo. In this sense, the intricacies of the concept and the literature on ideas suggests that they can be either constitutive or causal – either of which can promote or inhibit policy change. Constitutive ideas shape how human beings think and the broader landscape in which policy change is considered.

They frame what is considered possible and/or appropriate in a given situation and are interpreted as power in ideas (Carstensen & Schmidt, 2016).

Causal ideas, on the other hand, help us understand how circumstances or conditions are transformed into political problems and/or solutions within the political discourse and between different policy actors (Stone, 2012). For example, during the problem definition process, policy actors compete for control over the interpretation of a given policy issue so they can define the idea that will become the primary guide to policy (Stone, 2012). In this sense, policy change is driven by power through ideas and power over ideas (Carstensen & Schmidt, 2016). My case studies demonstrate both the constitutive and causal effects of policy change in the timing and scope of adoption of new mental health programs in BC and Ontario aimed at addressing the evolving anxiety and depression crisis through publicly funded and available psychotherapy. For a long period of time, mental illness was viewed primarily as a severe or serious illness where those who struggled with it were placed in psychiatric institutions. This idea changed during the deinstitutionalization era when it was understood that perhaps these individuals would be better served by receiving treatment in a community-based setting, although still initially focused on severe forms of mental illness. It also resulted in the *changing ideas* of the types of treatment that were deemed appropriate – branching out from institutionalization and followed by solely prescribing medication, there was a changing idea on the effectiveness of talk-based therapies. The landscape of what mental health meant was also changing in that it was not always severe or serious mental illnesses that were considered a mental health condition, but there was also a recognition of mild to moderate mental illnesses such as depression and anxiety as well.

The deinstitutionalization movement in Canada began in the 1960s and was specifically defined as "the process of discharging chronic mental health patients into the community in order for them to receive care from community mental health services (Spagnolo, 2014)." During this time period, the understanding and ideas surrounding mental health were focused on those with serious mental illnesses and dominated by the medical model of care and more specifically, psychiatry. This understanding and approach to mental illness priority, treatments and treatment providers is evident in both provinces. BC 's policy orientation focused on

patients with severe mental illness and the process of deinstitutionalization, with the province taking steps towards increasingly shifting their patients from Riverview Hospital to the community well into the 1990s (Read, 2009). Similarly, in Ontario, its first ever comprehensive mental health report, the *Graham Report (1988*) marked a new phase in mental health policy development in Ontario through the recognition of the need to shift towards a more community based treatment focus (Mulvale et al., 2007), but still continued to give priority to people who suffered from serious mental illnesses or disabilities.

Over the several decades while the deinstitutionalization movement and the increasing shift to the community care model (and the corresponding greater involvement of treatments and service providers more traditionally defined as non-medical) was slowly taking root and changing mental health treatment options and overall policy, it was not until the release of the 2006 Senate Report led by Senator Kirby when a greater focus in conversation of mental health took place. While there were some progressive developments in some jurisdictions from a mental health policy perspective prior to the Kirby report, such as the creation of the Mental Health Advocate in August 1998 in BC, the first-of-its kind in Canada at the time, the idea and understanding of mental health and treatment was still primarily focused on those with severe or serious mental illnesses and within psychiatric institutions.

The Kirby report served as a catalyst for shifting the focus in the mental health policy space from serious and severe illnesses to treating mild to moderate mental health disorders, such as generalized anxiety and depression. It was only after the release of the Kirby Report that some movement can be seen towards treating the growing and widespread problems of anxiety and depression outside of the existing healthcare system model. BC was the first province to respond to the call for community-based mental health reforms and aimed at less severe mental illnesses through its commissioning of CMHA-BC to investigate possible treatment options for addressing the anxiety and depression crisis. Based on its efforts and advice, the BC government adopted the Bounce Back program in 2008 as its policy response to the newly framed mental health crisis.

A similar occurrence happened in Ontario, albeit in a much different manifestation and not as evident on its face as in BC. Rather than pursuing a general population-based approach to the

depression and anxiety crisis, Ontario started by placing an emphasis on the mental health needs of children and youth across a range of policy areas and as a somewhat preventative measure. This population priority, however, reflected the newly constituted policy space and essentially jump-started the focus on anxiety and depression and youth mental health. Once gains had been made in this population, Ontario eventually transitioned into finding a means to provide greater treatment for the adult population suffering from those same disorders.

The strength of this new policy frame that focused on mild to moderate mental illnesses, such as anxiety and depression, was subsequently undermined by a new challenge in the mental health policy space. In BC, the evolving opioid epidemic shifted the policy priority focus to a new mental health crisis (a shift which seemed to happen later in Ontario). In the late 2000s and into the early 2010s, the momentum for mental healthcare in BC focused on anxiety and depression seemed high, albeit coupled with increasing concerns around addiction as noted in the *Healthy Minds, Healthy People* report of 2010. In April 2016 and after a half a decade of increasing addiction concerns, Provincial Health Officer Dr. Perry Kendall declared the opioid crisis as a public health emergency following a significant increase of drug-related overdose and deaths. In short, the window for anxiety and depression as the primary mental health concern closed almost as quickly as it had opened.

In contrast, the priority of addressing the anxiety and depression crisis in Ontario did not have to compete as directly with other mental health care concerns. The opioid epidemic crisis did not manifest in Ontario as it early as it did in BC, with the province not declaring a state of emergency until March 2020. Thus, while BC was struggling with the opioid crisis, Ontario was still in the middle of adopting mental health reforms aimed at the broader population and fixed on the prevailing mental health crisis of anxiety and depression as the core mental health policy concern.

(ii) Treatments

The solution to the depression and anxiety mental health crisis in both BC and Ontario was the introduction of a publicly funded psychotherapy program through the provision of CBT treatments and services. While other forms of psychotherapy could have equally been considered, both provinces seized on CBT as the potential solution to their mental health

problem. However, these policy responses differed between the two provinces and by two key interrelated components, namely the scope of mental health services as well as the underlying legitimacy of who would provide them.

In terms of the preferred scope of psychotherapy services, CBT was the clear winner in both case studies. In addition to publications on CBT identifying it as being the "gold standard" for therapy, many healthcare leaders also bought into the benefits and efficiency of CBT. Moreover, in Canada, the commonly referred to international example was the UK's CBT based *Talking Therapies* Programme. Talking Therapies is a nation-wide publicly funded program that aims to increase the availability of CBT to the UK population.

In BC, there was an initial embrace of low-intensity CBT as a potential solution to the anxiety and depression crisis by the CMHA – BC, the organization tasked by the BC government to provide it with policy options. CMHA - BC seized on this approach after meeting with Christopher Williams in the UK. The Bounce Back CBT-inspired program was particularly attractive because it could be offered easily and free of cost to individuals through phone, DVDs and workbooks. As Dr. Kimberley McEwan, former Provincial Project Manager for Bounce Back from CMHA BC stated, "The whole telephone delivery or coaching, at that time was rather novel… [although] it's obviously much more common now."[57] In addition to its ease of delivery, the program was also designed and sold as a program to support family physicians in referring their patients struggling with mild to moderate forms of depression and anxiety, and particularly at those struggling with other chronic medical conditions..

Attempts to expand the program beyond the initial low-intensity CBT model were unsuccessful. Despite the efforts of supportive healthcare professionals and CMHA – BC, the government did not seem interested in moving beyond the initial program adoption. This early support was subsequently followed by strong evidence of skepticism and disregard for whether a more comprehensive program would produce more desirable outcomes for the population at large.[58]

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[57] Kimberley McEwan (former Provincial Project Manager for the CMHA BC Division Bounce Back), interviewed by the author, July 7, 2022.

[58] For example, the CEO of CMHA BC, Johnny Morris specifically stated that Bounce Back generated more effective results than that of the UK's nation-wide program. In addition, a clinical counsellor from BC stated that they were

In contrast, when the government in Ontario eventually turned its attention to addressing the mental health crisis in the broader population, there were many prominent actors who advocated for the adoption of a provincially funded and larger-scale psychotherapy program that was inspired by the UK's Talking Therapies program. Ontario's influential healthcare leaders, such as Drs. Bob Bell, Catherine Zahn, David Gratzer and David Goldbloom, heavily advocated for a publicly funded psychotherapy program that modelled the full scope of the one in place in the UK. Dr. Zahn suggests that the emulation of the UK's Talking Therapies program as well as BC's Bounce Back (which is also UK-inspired) were not a result of widespread environmental scan on best practices for evidence-based decision making. Rather, the explanation for the policy choice was nothing more than just habits in terms of how decisions within health policy making has traditionally been done in Ontario. In addition to being the preferred policy choice of some of the leading policy entrepreneurs in Ontario focused on a broader scale psychotherapy program option, the piloting of the Bounce Back program by the CMHA York Region and South Simcoe also demonstrated the benefits and the potential of a low-intensity based program as well as reinforcing the need for a high-intensity option as well. In short, the solution to the anxiety and depression crisis was to focus on an already established treatment option from a preferred comparative jurisdiction as opposed to any type of wider investigation into the range of different treatment potentials.

(iii) Providers

Corresponding with the ideas associated with the comprehensiveness of the level of CBT services that could be made available to the public are ideas concerning the availability of treatment and service providers and their ability to provide the requisite level of care. The consideration of appropriate treatment providers in any health care space is complicated by the fact that the regulation of health care professions remains a provincial and territorial responsibility in Canada, with the possibility of thirteen different approaches. In addition, the landscape of counselling and psychotherapy also continues to evolve, sometimes rapidly, and becomes further complicated with different jurisdictions referring to psychological based

much in disagreement with the nature of the stepped-care model – which the UK model utilizes – in that in generates inequities in the delivery of service

professions with different titles such as “psychotherapist” and “counselling therapist” (Canadian Counselling and Psychotherapy Association, n.d.).

At its core, and as the Canadian Counselling and Psychotherapy Association (CCPA) stated: “the goal of professional regulation is to reduce the risk of harm to the public while maximizing the well-being of clients who are seeking counselling and/or psychotherapy services (Canadian Counselling and Psychotherapy Association, n.d.).” The ideas around regulation and the safe provision of psychological therapy were rooted in contrasting approaches in my two case studies – one rooted in exclusion (BC) and the other in inclusion (Ontario).

In BC, the regulation of psychotherapy (or the lack thereof) generated tensions between different types of mental healthcare providers on who was appropriate to collaborate and work with – both medical and non-medical. This was evident in 2007 with the legal proceedings in the *Utendale* case over the definition of who could call themselves a psychologist and who could practice psychotherapy. In this case, the College of Psychologists unsuccessfully sought to exclude non-medical service providers on the basis of ensuring the safe provision of psychotherapy. The resulting Court and corresponding government action did not reduce the underlying tension, contestation and efforts at exclusion and the corresponding lack of legitimacy of different types of mental health service providers.[59] The extent of the differences and focus on exclusion within the field bears repeating:

> “I do know that the Master of Social Work are quite proud of what they do and offer –and you know, good for them. But they don’t have any evidence-based therapy, right? CBT is the bread and butter for psychologists…But I think that what we know about what psychologists’ offer is that they have evidence-based treatments and MSW don’t. They do know resources and the community – which…that is great and navigating the world of disability. I think if they want to make a case in BC to the Ministry of Health for funding…it’s what’s the evidence? Can you get people better? If we invest this amount of money, show us that it’s worth it and I think psychologists have that body of knowledge generally whereas I’m not sure clinical counsellors and social workers have that.”

A Board Member from the BC Psychological Association stated:

> “You said psychological services – those places don’t provide psychological services; they provide counselling services…I tried to pretend that I was a person who needed mental health services. Some of them say who the provider is, some of them will say counsellor or social worker or nurse…I didn’t see any psychologists. And…bear in mind that counsellors are not regulated in BC. Are their mental health services effective? Do they do what they say they’re going to do? Is the

[59] Dr. Carole Richard (President, BC Psychiatric Association), interviewed by the author, May 31, 2022.

> money well spent? How many sessions do they provide to each person? What kind of benefits are there? Maybe they're amazing, maybe they're doing some ground-breaking work, maybe the outcomes are phenomenal. Does anyone know? Is anyone doing any outcome measurements? Because it's arms-length, right? It's not THE government – it's community-based organizations that are propped up by the government; they're provided additional funding."[60]

This resulted in a fractured treatment option environment and a corresponding lack of coordinated advocacy for a more robust and fully scoped psychotherapy program.

In contrast, in Ontario, while the road to regulation for mental health professionals was not without tensions and struggles, it was a less contested policy space over different types of treatment providers and focused on a broader inclusive approach. This was evident in the evolution of the regulation of mental health providers, starting in 2006, when the provincial advisory council of Ontario recommended that psychotherapists be regulated due to the risk of harm associated with unregulated practice by unqualified service providers. The following year, in 2007, through the *Health System Improvement Act,* the provincial government introduced the *Psychotherapy Act, 2007* to enable the regulation of psychotherapy and added the "controlled act of psychotherapy"[61] under the RHPA and culminating in its eventual implementation in 2015. The new Act both implicitly and explicitly included a range of potential service providers and gave the practice of psychotherapy and the whole of the service provider field a greater degree of legitimacy. This meant that there was both greater service capacity across a range of mental health treatment providers, but also that they were all viewed as legitimate and safe treatment options that could provide services in a broader psychotherapy program.

Overall, there were different approaches in the two provinces as to how to regulate the provision of psychotherapy and ensure its safe delivery by regulated professionals. In BC, where interviewees suggest the exclusion of unregulated professionals appears to have been the preferred approach, there remained the ongoing and competing contest over appropriate treatments and treatment providers that was a seemingly settled debate in Ontario. Whereas Ontario was moving towards a more inclusive approach to the regulation of psychotherapy providers and had recognized the treatment space as one that was open to a range of treatment

[60] BC06 (Board Member, BC Psychological Association), interviewed by the author, June 7, 2022.
[61] Definition: Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning" (CMHO, 2018).

options, in BC, there was still resistance and tensions within the broader mental health policy and services community towards who should or could provide evidence-based mental healthcare services, such as psychotherapy. This ultimately proved to be important in shaping the provinces' understandings of who *can* and *should* deliver mental healthcare services, such as psychotherapy. In the case of Ontario, psychotherapy became a regulated profession, and this process opened up an understanding that there were numerous qualified allied mental health professionals who could deliver mental health treatments, including CBT therapy. In contrast in BC, the lack of regulation of counsellors and psychotherapy further reinforced tensions and skepticism between different mental healthcare providers in terms of who was best positioned to provide CBT therapy.

Summary of Ideas

The story of what took place in terms of the provision of publicly funded CBT in BC and Ontario is complicated by the part that three different sets of interlocking ideas played. The evolving shift into community-based treatments undertaken with deinstitutionalization in both provinces led to a potential opening of the policy space to non-medical treatment providers. The ensuing crisis in the mental health policy sphere of the early 2000s focused on anxiety and depression, as identified and explored through the Kirby report, opened up space for new treatments and new treatment providers to play a greater role in the planning, design and delivery of mental health care in both provinces. The federal government's release of the 2006 Kirby Report was instrumental in framing and bringing to light a healthcare issue that had been historically overlooked and underfunded. It also led to the consideration of broadening the initial understanding of how mental health was viewed and perceived. For a long period of time, mental illness was viewed primarily as a severe or serious illness where those who struggled with it were locked away in psychiatric institutions. This idea changed during the deinstitutionalization era when it was understood that perhaps these individuals would be better served by receiving treatment in a community-based setting, although still initially focused on severe forms of mental illness. It also resulted in the *changing ideas* of the types of treatment that were deemed appropriate – branching out from institutionalization and followed

by solely prescribing medication, there was a changing idea on the effectiveness of talk-based therapies. The landscape of what mental health meant was also changing in that it was not always severe or serious mental illnesses that were considered a mental health condition, but there was also a recognition of mild to moderate mental illnesses such as depression and anxiety as well. As might be expected, the presence of the anxiety and depression crisis provided an opportunity to differently constitute those policy spaces, albeit constrained by the other and intersecting ideas associated with the necessary scopes of treatment and the legitimacy of treatment and service providers.

In the newly contestable policy space opened by the anxiety and depression crisis, there was agreement between both provinces as to the appropriate form of treatment, namely CBT. Both provinces adopted CBT as the legitimate and preferred approach to dealing with anxiety and depression from policy actors in the UK, although the two provinces ultimately differed on the scope of that type of treatment. In BC, the initial role played by CMHA – BC framed the policy option as a more limited response through the recommendation for adoption of the lower intensity option of the Bounce Back program. In contrast, Ontario opted for a more intense mix of lower and higher levels of talk therapy and emulating the IAPT program from the UK.

Part of the explanation for the different scopes of appropriate levels of treatment is rooted in the understanding of the appropriateness of treatment providers in the mental health policy space in each province. Constitutive ideas can not only open up opportunities, they can also shape individual identities and social perceptions. It was discovered through my two case studies in Ontario and BC, respectively that within the mental health policy space, there is a debate with the psychotherapy space in terms of who is a qualified service provider. In the case of Ontario, there were a small group of prominent physicians who believed that the delivery of both low and high-intensity CBT psychotherapy could be delivered by a non-physician or PhD Clinical Psychologist. Inspired by the UK's Talking Therapies model, there was a strong idea that CBT would also be delivered through allied mental health professionals to treat mild to moderate mental health illnesses such as anxiety and depression.

In contrast, in the case of BC, there was a visible divide between the mental healthcare service providers – i.e. the medical professionals, psychologists, and unregulated clinical counsellors. The fractured treatment provider environment is consistent with the non-medical based CMHA – BC only initially advocating for a lower intensity program and the continued contestation over the need and value of higher intensity programs. The push towards a larger-scale program in Ontario was also strengthened by the greater capacity to deliver treatment services due to the increased availability of a wider range of treatment providers that corresponded with the changes to the regulatory environment for mental health care professionals that was lacking in BC. This was also strong evidence of constitutive ideas in that there was an acceptance in Ontario that the delivery of mental health services was not only provided within – as it had traditionally been – in hospitals and physician-based care, but also by other allied non-medical professionals and that there was a corresponding capacity to do so.

One aspect of the ideational environment that may have been surprising was the extent to which how rapidly it changed in BC while remaining stable in Ontario. The emergence of the opioid crisis so much earlier in BC than in Ontario may have impacted the ability of the broader BC psychotherapy policy community to work out some of the exclusion-based differences in treatment and treatment providers existent in that policy space. In contrast, a much more receptive and inclusive policy environment in Ontario had more time to explore the scope of treatment and the range of treatment and service providers.

Institutions

The historical institutionalism literature suggests that during critical junctures, where there is a significant policy change, decisions will be made which will result in policy legacies that impact policy developments in the future (Pierson, 1993). The concept of a policy legacy refers to the manner in which "institutions, processes, and ideas belonging to past policies .. still persist in the present and affect the way policies are designed and implemented" (Nesti & Graziano, 2025). This is why it is important to examine the policymaking process in within its historical context, because past decisions determine or impact future policy decisions as well (Hacker, 1998). The adoption of psychotherapy programs to deal with the anxiety and

depression crisis in BC and Ontario both demonstrated the power of policy legacies as well as their ability to be partially overcome. In particular, the previous organizational arrangements of the healthcare systems in general and the prevalence of the medical model of care both influenced the policy choices made by the respective governments in each of my case studies.

One of the novel insights provided by examination of the mental health systems in Ontario and British Columbia in an environment of change concerns the role of the broader institutional environment. The institutions literature defines veto players as "individual or collective actors whose agreement (by majority rule for collective actors) is required for changing the status quo" (Tsebelis, 1995) The argument is that the potential for successfully achieving policy change decreases as there are more veto players. This is because as the number of players increases, the likelihood of a lack of congruence and/or cohesion among veto players rises – which is similar to the "too many cooks in the kitchen" analogy. However, the results of my two case studies show that this expectation may not be as applicable or perhaps as universal as suggested or as expected.

In terms of healthcare governance models, both British Columbia and Ontario operated under similar delegated systems of authority, where the provincial governments allocated decision making authority concerning the structure, availability of publicly-funded treatments and relevant service providers, to appointed government bodies. In the case of BC, their healthcare governance consisted of a total of 5 regional health authorities (RHAs**)** in addition to the BC First Nations Health Authority and the Provincial Health Services Authority. The structure in Ontario, at the time, was also that of a regional governance model, called Local Health Integration Networks (LHINs) and which had the legislative authority to restructure, merge and close facilities within their regions and plan the delivery of healthcare within their jurisdictions.

While both regional in authority, one key difference between Ontario and British Columbia was the number of players in this context – with there being only five regional health authorities in BC and fourteen in Ontario. With this disparity in number of institutional actors, there may have been the expectation that the more limited numbers of health authorities in British Columbia would have permitted a greater ease of coordination and implementation of a comprehensive system, given the limited number of players and fewer veto points. However,

this was not the case as the RHAs in BC are extremely autonomous and tensions between them made it difficult to collectively agree upon much, if anything, at all. As my interviewees previously stated, "nothing in British Columbia is centralized and piecemeal" as it is the individual regional health authorities who plan and deliver their own respective mental health services, which are provincially funded and managed. This, in turn, made it difficult to adopt a province-wide program.

As a result, Bounce Back was driven primarily through the Ministry of Health Services in the province and was pursued as much as a greater overall health system reform, and particularly aimed at primary care reform designed to ease the burden on family physicians and other mental health service providers, as it was an efficient and extremely low-cost solution to the overall mental health crisis in the province. In other words, it was viewed as an incremental change focused on maintaining the existing system of care and with the provision of only minimal supports and without the need of consulting with or getting the buy-in of the regional health authorities.

At the same time, the overall lack of coordination and, perhaps, fractiousness of the regional health authorities and the lack of policy capacity on program implementation at the provincial government level, meant that the government had to pursue the design of its mental health policy response through specialized interests, such as the CMHA-BC. This placed CMHA – BC at the forefront of the policy investigation and determination process. The smaller number of veto players through the regional health authorities with divergent ideas and interests were barriers to achieving policy change due to increased differences in opinions among prominent decision makers.

In contrast, the greater number of potential institutional actors in Ontario demonstrated from the outset that there would be a need for greater levels of coordination and central authority that comes with a greater and more diverse number of players and veto prospects. As a result of this greater level of centralization, it eventually provided an opportunity for actors within the Ministry to pursue innovative policy solutions to the ongoing, mental health crisis in the province.

Summary of Institutions

In both of my case studies, the evidence of policy legacies was also present from the prominence of the medical model, in which early decisions determined that physicians were covered under public health insurance (OHIP for Ontario and MSP for BC, respectively), whereas non-medical allied mental health professionals (i.e. psychologists) were not. In the context of mental health and the healthcare space broadly speaking, this privilege provided physicians with immense power in terms of bargaining, as well, in some ways, shaping health policy. Meanwhile, allied mental health professionals, such as psychologists, learned to find their place outside of the public healthcare system – in the private sector (Mulvale et al., 2007).

In BC, my empirical chapter sheds light on how the adoption of Bounce Back also did not occur without any tensions or conflicts. The initial adoption of Bounce Back into the province was framed not as general psychotherapy program for the benefit of the whole of the population. Rather, Bounce Back was selected as a support mechanism for helping people with chronic illnesses manage those additional mental health challenges of those conditions. In addition, the program was framed and sold as a support mechanism for family physicians in the province in order to get their buy in. The notion of the program being delivered by certain providers without the education and training was also a concern for healthcare providers, namely psychologists as well as physician providers. As Dr. Kimberley McEwan, former Project Manager for the CMHA BC, Bounce Back Program stated that there was "a lot of resistance" as regulated professionals such as psychologists "felt it was professional function" that "could [not] be a delegated function." While the idea was novel that at the end time it was a program that was delivered through the telephone and was arguably "less risky," there was still murkiness in terms of who was qualified to deliver such services.

In Ontario, despite the fact that there was strong support from influential healthcare providers such as physicians Drs. Bob Bell and Catherine Zahn as well as other healthcare leaders, the prominence of the medical model was not absent. This was highly evident early on during the three-year pilot for the OSP program which took place from 2017-2020 at four prominent mental health hospitals in Ontario: Waypoint, Ontario Shores, CAMH and The Royal. This stirred tensions as it was contradictory provided the nature of (as well as the vision) of the

OSP as a province-wide, publicly funded, community-based mental health program, yet it was the four psychiatric hospitals that received funding alongside the Canadian Mental Health Association (to deliver Bounce Back).

In Ontario, despite the benefits of community-based mental health services being at the core of the argument and conversation, prominent psychiatric hospitals were funded during the pilot phase of the Ontario Structured Psychotherapy Program and which was coupled with the importance of advocacy and support from prominent and institutionally well-placed physicians. In contrast, support for an expanded psychotherapy program was lacking support from physicians. This lack of a range of supportive and institutionally well-positioned actors interested in pursuing more comprehensive CBT programs in BC also meant that the initial adoption of a more limited program based on less formal professional requirements, as introduced and advocated for by CMHA BC, remained the default. As Bounce Back took root, there became less urgency in pursuing high intensity forms of therapy as an option.

Policy Learning

At the most general level, policy learning is defined as "adjusting learnings and beliefs related to public policy (Dunlop & Radaelli, 2013b)." To further elaborate, this means that policy learning allows for policymakers to gain an increased understanding of their policy issue at hand by comparing theirs to other jurisdictions. This ensures that prior to deciding on how to address a policy issue, ideally, policymakers have come across the best and more recent evidence at hand. Thus, when jurisdictions are faced with a policy problem, they generally have two opportunities to learn: (a) from their own experiences (self-learning) or (b) from other jurisdictions (foreign learning). This is also known as 'lesson-drawing' (Hacker, 1998). Policy learning includes positive (what to do) and negative (what not to do) aspects (Rose, 1991). In the case of the mental health crisis in Canada, there is evidence of learning from both jurisdictions, albeit mixed or in different ways, and of different types of learning overall.

On the positive learning front, BC was initially inspired by the provision of mental health care services in the UK. Through the pursuit of options explored and understood by the CMHA – BC, BC adopted a program that was previously designed by Dr. Christopher Williams, a

psychiatrist and an Emeritus Professor of Psychosocial Psychiatry at the University of Glasglow, Scotland, UK. In particular, he created a CBT-inspired self-help mental health program that was reflected in BC's creation of Bounce Back. The learning literature states that this form of policy learning is that of "copying" which is defined as "enacting a more or less intact [existing] program" (Rose, 1993) and represents positive learning by BC. Ontario also demonstrated evidence of positive learning by adopting a more comprehensive CBT based therapy program and which was largely inspired by the UK's model, which provides a combination of both low and high-intensity CBT treatment options. Similar to BC's adoption of Bounce Back, in this case, the type of foreign learning that occurred was copying. This experience was conditioned by an earlier and more localized learning opportunity through the initial trialling of Bounce Back in Ontario in the York Region in addition to the successful three-year long (2017-2020) four pilot sites at the four mental health hospitals in Waypoint, CAMH, Ontario Shores and The Royal. The Ontario experience also demonstrated self-learning through Rebecca Shields' experiences in BC (where she had previously served as Executive Director in CMHA BC, Vancouver Burnaby Branch) and as a result, understood the benefits the Bounce Back program could similarly provide in Ontario.

Evidence of negative lesson drawing was also present in the response to the anxiety and depression crisis, at least in British Columbia. In particular, it was viewed later through my interviews with CMHA BC CEO, Johnny Morris who shared that the Bounce Back program, despite being low-intensity, was much more cost-effective and producing better results than the UK's nation-wide model. Thus, there was skepticism in BC towards the UK program, which in turn, certainly contributed to the lack of interest in pursuing a similar type of more comprehensive program after Bounce Back's initial successes.

A key finding that my case studies highlighted – that is underexplored within the existing literature within the existing policy learning literature – is the consideration of how timing impacts the scope of policy change. Specifically, in the case of BC, they moved "early and small" in 2008 through the adoption of the Bounce Back program. Similarly, the UK's nationwide program, *Talking Therapies,* was also launched in 2008. This meant that given that the timing and launch of both programs occurred simultaneously, there might not have been sufficient

time for BC to effectively learn and understand the benefits of the UK model as a whole at the time. In the case of Ontario, they only began their pilot program in 2017, thus, there was more time to observe and learn from international examples deemed as the "golden standard" (Williams, 2015) such as the UK to determine which existing model would be the best fit within the Ontario context.

Finally, as the existing literature on policy learning states, demonstrating evidence of policy learning can be difficult as the concept can be ambiguous, difficult to measure, and can happen without any policy change occurring (Moyson et al., 2017). This was evident in my case studies, particularly in BC where policy learning occurred and both influenced the policy outcome through the adoption of Bounce Back, but also did not influence or change policy outcomes towards the adoption of a more comprehensive CBT program. However, more obvious forms of learning such as copying or emulation were observed in both of my case studies, through the OSP program and Bounce Back program, respectively.

In addition, given that BC was facing a massive opioid crisis, which they declared as a state of emergency in April 2016, it was likely that policymakers were unable to dedicate their time and attention to expanding Bounce Back to reflect the more comprehensive model, even if they were interested. Bounded rationality means that policymakers have limited resources such as time, knowledge and attention when it comes to dealing with many competing policy problems. As a result of that, many policy issues which are viewed as low priority will not make the policy agenda, which in turn, result in no policy change occurring. This means that a jurisdiction can have access to the most up-to-date policy information or knowledge of "best practices" and still not adopt a policy or program due to a wide array of reasons and factors which are not limited to: leadership who are against the idea (where reasons may be personal or otherwise), which was observed within the BC Health Authorities by my interviewees, as well as organizational and institutional pressures. Healthcare organizations and sectors are complex and highly political, and it was evident that actors in BC, such as Drs. Mark Lau (former Scientific & Clinical Advisor for Bounce Back at CMHA, BC) and Patrick Smith (previously Vice President of Research, Network and Academic Development at the BC Provincial Health Services Authority), and Peter Coleridge (formerly Vice President, Education and Population Health at BC Provincial

Authorities), struggled to get the ear of the BC government and relevant policymakers, thus, despite learning having occurred, the adoption of a province-wide psychotherapy program was not feasible.

Policy Entrepreneurs

Many of the public policy process theories privilege the role of individual policy actors in leading to policy change, not the least of which is the multiple streams framework (Kingdon, 1984).[62] In this approach, particular policy actors take centre stage in leading to policy change through their actions as "policy entrepreneurs". The literature defines policy entrepreneurs as "energetic actors who engage in collaborative efforts in and around government to promote policy innovations". Policy entrepreneurs generally share common attributes, skills and strategies such as ambition, credibility, strategic thinking, networking, problem framing, and leading by example (Mintrom, 2019). As Kingdon (1984) also notes, policy entrepreneurs are actors who "could be in or out of government, in elected or appointed positions, in interest groups or research organizations." While the existing literature largely discusses policy entrepreneurs in the context of using their skills and attributes to achieve policy change, at the same time, they can also leverage their skillsets to block policy change and/or maintain the status quo. Finally, as with policy learning, policy entrepreneurship can be difficult to detect at times, with there being different measures for identifying actors as such and with a corresponding requirement that links entrepreneurship to outcomes.

In my two case studies, policy entrepreneurship was the most evident in Ontario. Drs. Bob Bell and Catherine Zahn were physicians by training but were also well-known healthcare leaders within their respective fields, with Bell serving as CEO of the University Health Network, and Zahn serving as CEO at Canada's top mental health hospital CAMH before Bell went on to serve as Deputy Minister of Health from 2014-2018. Leveraging both of their strong and prestigious networks through their medical associations and eventually the bureaucracy, they both played strong roles in the adoption of the province-wide program in Ontario. The role that

[62] See also the primacy of the role of actors in Punctuated Equilibrium Theory (Baumgartner and Jones, 1993 and 2009) as well as the Advocacy Coalition Framework (Sabatier, 1988).

Drs. Bob Bell and Catherine Zahn took on were that of what the public policy literature would refer to as policy entrepreneurs and they were identified as such by a number of my interviewees.

The CEO of CMHA South Simcoe and York Region, Rebecca Shields similarly also took on a policy entrepreneurial role through pitching to the LHIN at the time for the adoption of the low-intensity CBT program, Bounce Back, which she had gained familiarity from during her time as Executive Director at CMHA BC. Certainly, provided there was already a strong appetite for the delivery of a publicly funded psychotherapy program within the province that could be delivered by non-physician and PhD-level psychologists, her efforts at advocating for a trialing of Bounce Back would have allowed for this to be more feasible in Ontario as well.

The case of BC presents a more complicated role for policy entrepreneurship and demonstrates some difficulty in defining the categorization of actors as entrepreneurs as opposed to more context specific situations. In this case, rather than individual policy actors taking on an entrepreneurial role, it was the non -profit mental health organization, CMHA-BC that filled this role. The provincial government approached CMHA–BC with a small pool of leftover funding from the fiscal year of $6M to investigate and pursue a policy response for the anxiety and depression crisis facing the province. As a result, the organization was provided the opportunity to act as a change agent to bring forward – what was considered at the time – a novel CBT-based program, Bounce Back to the province. In this circumstance, CMHA— BC acted as change agents that would meet the definition of policy entrepreneurs. However, later, when discussions surrounding creating a more comprehensive program, such as the UK's Talking Therapies program or Ontario's OSP program, arose they were unable to gain the attention of the government, let alone advocate for a more comprehensive program.

This shifts the perspective to that of a case of unsuccessful policy entrepreneurship through the PhD-level psychologists who worked at a prestigious mental health hospital, CAMH and the BC Health Authorities, Drs. Mark Lau and Patrick Smith, as well as Peter Coleridge. As my BC interviewees shed light on, there was lack of appetite from the BC government (which was largely preoccupied with the opioid crisis) as well as lack of support from BC physicians, thus, it was difficult to advance their policy agenda, despite having social status, knowledge,

access to prestigious networks and resources. Eventually, their efforts coalesced around the low-intensity CBT treatment option and their position remained quite resistant and satisfied with maintaining the current status quo as a form of mental healthcare service delivery. As CEO of CMHA—BC, Johnny Morris stated, the UK program "needs good scrutiny" and that their Bounce Back program "boasts a better recovery rate" at 50%. On this basis, we see three different aspects of entrepreneurship: the success of CMHA – BC in the initial design and implementation of the Bounce Back program; a corresponding lack of success in pushing towards a more comprehensive model and, finally, an acceptance and embrace of the status quo.

Conclusion

In summary, the case studies within this dissertation demonstrate that wicked problems and complex policy spaces, such as mental health policy, rarely conform to singular theoretical explanations. Instead, they require a pluralistic theoretical approach to both examine and understand the multiple, overlapping causes and factors at play. As this dissertation demonstrates, it is only by drawing from multiple theoretical frameworks that we achieve a richer and much more realistic understanding of how such wicked policy problems evolve and are addressed.

Future Directions for Research

The work in this dissertation was important as it contributed to an area of health policy that has been under-researched, particularly from a comparative public policy lens. As mentioned in Chapter 2 and as Mulvale (2007) notes, the majority of the research done within mental health policy in Canada are done with single case studies or at the federal level. Additionally, the Ontario Structured Psychotherapy (OSP) Program is a new and novel program which from a public policy lens (as well as in general) remains under-examined. With that being said, I assume that the following research work that will be done on the OSP program will be largely based on program evaluation to assess the impacts and shortcomings of the program itself. While there is existing literature on the general background of the details of the program,

in terms of its history, interviews with stakeholders and key policy actors, my dissertation is quite novel in this sense and will contribute to an increased understanding of mental health reform for other jurisdictions, particularly in the Canadian context.

In terms of future research directions which build on this dissertation, on July 2, 2024, the Government of BC announced that designated Psychotherapy as a health profession under the Health Professions Act. The proposal had received cabinet approval and been signed by the Lieutenant Governor. In other words, the province of BC has moved towards regulating psychotherapy so that those with titles such as clinical counsellors and psychotherapists will also be subject to government oversight (CBC, 2024). This dissertation does not explore this monumental announcement, provided it focused on demonstrating how ideas within mental healthcare are reflected in a constitutive sense or how they impact how human beings think and make decisions. In other words, this dissertation largely focused on answering the question of why BC, who moved early, did not adopt a large-scale psychotherapy program, whereas, Ontario, who moved later, did. A major explanation was that the ideas among healthcare providers and leaders in Ontario, particularly influential physicians who took an entrepreneurial role, were that there were a wide range of mental healthcare providers who could offer psychotherapy services. In the case of BC, this idea was not as strongly present as evidenced through interprofessional conflicts among other medical and non-medical mental healthcare providers, and tension between regional health authorities. In addition, while there were short attempts of entrepreneurship, it was ultimately insufficient and unsuccessful in changing policy outcomes in the province. Thus, next steps for research in this area would be to explore how the regulation of a health profession such as psychotherapy influences policy outcomes.

More broadly, the mental health policy implications of this dissertation highlighted several important insights which may help influence future mental health policy outcomes in other Canadian. First and foremost, *ideas matter,* but more specifically, elite ideas within a policy space matter, which in the case of mental health, are physicians. In Ontario, the evident advocacy and strong public support demonstrated by physicians for their non-medical allied healthcare colleagues proved to play a prominent role in Ontario becoming Canada's first province to adopt a publicly funded psychotherapy program. In contrast, there was a visible

divide among medical and non-medical healthcare providers in BC, which proved to be a barrier in the adoption of a province-wide program.

Secondly, policy entrepreneurship matters in achieving policy change. The UK's nation-wide psychotherapy program, *Talking Therapies* programme, was spearheaded by two key policy entrepreneurs, Drs. David Clark, a psychologist and Richard Layard, an economist, who were able to make a compelling case on the cost-benefits of adopting a publicly funded nation-wide program to Blair's Labour Government, at the time. In addition to showing evidence of direct learning through adopting the UK program on a smaller scale, Ontario, albeit unintentionally, understood the importance of this, which was evident through the work of various physicians within government and outside of government. In the case of BC, while there were some attempts from individuals, it proved to be a struggle, likely due to the lack of collegiality among medical and non-medical healthcare providers to achieve similar policy outcomes as Ontario.

Third, while policy learning was evident in Ontario and BC, through adopting UK-inspired programs within their respective provinces, OSP and Bounce Back, as Dr. Catherine Zahn states, the evidence of policy learning in the case of Canada usually looking to our Westminster colleagues, the UK and Australia are by no means a coincidence nor new, but perhaps a habit many Canadian health policy researchers are guilty of. The long-standing relationships to these jurisdictions prove to be a factor when "policy learning" or research for best practices are performed, but this does beg the question of: "Are we limiting ourselves from other potential best practices by not looking more broadly?" The digitization of records and research tools in the health policy space, such as artificial intelligence, provides both researchers and policymakers alike a significant opportunity to broaden our comparative lens in the area of health policy. Enhanced digital access can allow for quicker and easier access to international data, grey literature, and global case studies, making it more feasible for researchers to identify and analyze policy innovations beyond our default jurisdictions, such as the UK and Australia.

Finally, the role of institutions will also play a factor in policy change, even if it is achieved. In the case of Ontario, from a bird's eye view, this was a success story where it became the first province to adopt a publicly funded psychotherapy program. However, my

interviews showcased the prominence of the medical model through the behind-the-scenes struggles of the OSP during the pilot stage – where despite this program being intended for individuals for mild to moderate mental health concerns, the four mental health hospitals were funded for a larger amount than the non-profit organization, CMHA. In the case of BC, it was highly evident, based on the interviewees from physicians and PhD-level psychologists, and their ideas on who should and should not provide certain modalities of mental healthcare.

Looking ahead, there is significant opportunity to build on the findings of this dissertation provided mental health remains underexplored in the broader public policy literature, particularly with respect to psychotherapy. A promising avenue for future research would be to conduct a cross-provincial comparison of psychotherapy programs and policy changes across Canada. As of April 1, 2025, psychotherapy is currently regulated in Ontario (College of Registered Psychotherapy of Ontario), Quebec (Ordes des psychologues du Québec), Nova Scotia, New Brunswick, and Prince Edward Island. However, it is important to differentiate that in Ontario and Québec, psychotherapy is regulated, whereas in the latter three Nova Scotia, New Brunswick, and Prince Edward Island, counselling therapy is regulated. Despite the different titles, Canadian Counselling Psychotherapy Association has shared that all the professions "share similar scopes of practice, standards for professional preparation, continuing education requirements, codes of conduct, and standards of practice (Canadian Counselling and Psychotherapy Association, 2025)." Thus, this means there is an immense opportunity to explore how these other jurisdictions, which regulated therapeutic services vary in terms of their decisions to adopt a province-wide publicly funded psychotherapy program. Finally, in the remaining eight jurisdictions where psychotherapy has not yet been regulated, there is also similar opportunity to explore the barriers to regulation and how it impacted policy outcomes.

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