



OPEN MINDS: BETTER MENTAL HEALTH CARE

Unleashing the power of technology to deliver psychotherapy

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Canada's health-care system suffers from the broken-leg syndrome. It works best, if imperfectly, at patching up people, responding to the acute crisis: a heart attack, a rampaging tumour, a busted femur.

It's the same with mental illness. The twentysomething with schizophrenia in a state of psychosis delivered by police to the hospital emergency room rightfully demands attention. The twentysomething struggling with depression who can't get out of bed in the morning? The lineup for him is over there.

For many patients, coping with mental illness is like being expected to function while dragging around a broken leg. Do that for too long, and you need more than a cast to fix it. When money is tight (and when isn't it?), governments get nervous about expanding public coverage of health care – even if that funding would mean giving those with mental illness the most scientifically supported care in the same way we would for a heart patient.

But this is a world abounding in technology. Helping many of these patients – quickly and cost-effectively – may be as simple as turning on a computer or smartphone. Over the past few years, the research supporting tech-based psychotherapy has been steadily growing; in some studies, for mild and moderate cases, this approach works as well as face-to-face therapy.

In Britain, self-directed therapy with telephone support is the recommended first response in a massive new program to increase access to publicly funded psychotherapy. It's huge in Sweden and Australia, where studies consistently show that it works for many different disorders.

So why isn't it more widely used in Canada, where one of the big issues crippling mental-health care is a lack of access to psychotherapy? With smaller centres in short supply of psychiatrists and psychologists, private therapy costly and mild cases of depression and anxiety shunted onto wait lists or improperly medicated, tech-based treatment has enormous potential, especially for early intervention.

Online- or phone-based therapy can be effective for patients dealing with depression and anxiety wrapped around a chronic illness, for mothers with postpartum depression, for obsessive-compulsive disorder, for post-traumatic stress disorder.

"It could make a huge difference for a lot of people," says University of Regina psychologist Heather

Hadjistavropoulos, who is running a provincewide online therapy pilot project.

Among her patients are people with no other way to get treatment “because their disorder is so severe they wouldn’t ever leave the house,” she says.

It maintains the privacy of anyone reluctant to be seen wandering into a mental-health clinic, holds appeal to young people who are most likely to prefer therapy to drugs, and opens up options for patients who can’t miss work or school.

Consider 13-year-old Nick Wroblewski, who wasn’t keen on spilling his problems to a stranger. But his parents were growing increasingly worried about him. After the death of his grandmother, he had begun to worry about burglars and natural disasters, obsessively researching crimes in their neighbourhood and reading up about tsunamis. Then last year, after his grandfather came to Langdon, Alta., to stay with them while receiving palliative care, Nick began complaining that he couldn’t feel his hands and feet, and his marks fell in school. Their family doctor suggested these were symptoms of anxiety.

Eventually, his parents learned of the Strongest Families therapy program, based out of Nova Scotia but funded through the local health region, that offered an alternative to medication, spared Nick the stress of office appointments and included family members.

For eight sessions, over several months, Nick and his mother, Amy, received weekly phone calls from a trained counsellor, watched a video and filled out a notebook, learning the signs of anxiety and coping measures, such as mindfulness, to improve symptoms.

Sitting down to his December exams, Nick practised the belly breathing exercises he had learned. He made the honour roll. His anxiety is under control, his mother says. He is still curious about the world, she says, “but not afraid of it.”

Strongest Families is just one of a growing number of programs scattered across the country that, too often, neither patients nor doctors know about.

One of the most well-studied programs is being run by the Canadian Mental Health Association in British Columbia, a booklet-based therapy with short telephone coaching, called Bounce Back (adapted from Britain’s national program). With an annual budget of \$1.9-million, the program handled about 5,000 referrals last year (3,000 people went on to sessions in the program) although CMHA estimates it could increase its caseload by one-third without additional costs.

Among patients who “complete” counselling – clients received, on average, four coaching sessions and requested eight or 16 workbooks – 69 per cent see their symptoms fall below clinical levels of depression and anxiety. Those with less severe symptoms do even better.

The program is now being trialled in Toronto and Nova Scotia, where the B.C. coaches are working with East Coast clients, a time difference that allows for after-work phone calls.

The program “is a game changer for Canadians who continue to wait for, or can’t afford, private talking therapies,” says Bev Gutray, chief executive officer of the B.C. chapter of CMHA.

The online therapy program for adults developed at the University of Regina and being trialled in Saskatchewan receives about 50 new referrals a month, although Hadjistavropoulos says that “we are just scratching the surface.” (Again, one of the hurdles is getting doctors to refer their patients.)

The Strongest Families program, which worked for Nick Wroblewski, has contracts with a handful of health authorities and agencies across the country; to date, the program has treated about 5,000 children with conduct disorder and anxiety.

Another program is being piloted at Toronto’s Centre for Addiction and Mental Health.

In all cases, counsellors stay in touch with patients either by e-mail or phone – in some programs, this amounts to as little as 10 minutes a week – an important human contact that research has found keeps patients in the program and boosts recovery rates.

This kind of support is usually based on cognitive behavioural therapy (CBT) – a thought-changing, skills-focused treatment, with structured manuals and homework components, that lets patients work independently with a therapist’s occasional guidance. A 2014 study of the Saskatchewan program found that 80 per cent of patients completed the eight-week course and 95 per cent were satisfied with the program and reported an improvement in their symptoms – a benefit that held three months later.

According to Strongest Families president Patricia Lingley-Pottie, who is also a researcher at the IWK Health Centre in Halifax, 90 per cent of families complete the program, with short-term recovery rates of 88 per cent. It costs about \$1,000 a child, including weekly calls from a counsellor; for Nick’s family, this cost was covered by the local health authority.

Michael Kapusta, a family doctor in Swift Current, Sask., has referred several patients to the University of Regina’s online therapy program, including a 33-year-old father suffering from panic attacks. Kapusta diagnosed the patient with anxiety and prescribed medication, but felt he would benefit from therapy, as well.

Swift Current is currently without a psychologist – the last one moved to a larger city – and the mental-health clinic offers only counselling.

While his patient could afford more intensive psychotherapy, Kapusta says he would have to drive at least two hours one way to get it. Instead, he did the online CBT program, completing the units with his wife at night. “After a month or two, she noticed a big change,” Kapusta says. “They were going out in the evenings. He was more like himself.”

Dawna Karalash, a registered nurse who works at a mental-health and addiction day program in Regina and is trained in CBT, takes one afternoon a week to provide the online support. She typically handles two patients at a time, mostly addressing questions by e-mail. Usually they relate to how to apply specific lessons to their individual situations.

Karalash has worked with a dozen people so far, and almost all of them ended the program with their symptoms in the mild range. Many of them improve dramatically after the first lesson.

“I think it’s very empowering, that you aren’t stuck with something you can do nothing about,” Karalash

says. “You don’t have to wait for your medication to kick in.”

Like all treatments for mental illness, tech-based therapy isn’t intended for every patient and doesn’t work for everyone. As with face-to-face sessions and medication, dropout rates can be high, and it has been found to work best for those who choose it, since it requires people to be motivated to complete the sessions. It is designed mainly for people with less-severe symptoms and requires careful screening and a “step up” in treatment if a participant’s condition worsens.

But it’s a first step – a cost-effective approach to early intervention that, Lingley-Pottie points out, saves the system money down the road.

Speaking of her families, she says, “The goal is to catch them [early] in the hope that they will learn these skills and implement them throughout their lives, and never have to access mental-health services again.”

The gold standard of psychotherapy

While research shows positive results for mindfulness and interpersonal therapy, cognitive behavioural therapy (CBT) is currently the gold standard of psychotherapy, mainly because it’s the most well studied, having evolved to be results-based and quantifiable in a way that more open-ended psychoanalysis has not.

How does it work?

CBT is a structured, time-limited form of therapy that focuses on changing the negative thoughts and perceptions of patients, and giving them specific skills – and homework assignments – to cope with symptoms. It was developed by Andrew Beck, who published the first randomized controlled trial of its use in 1977, and who theorized that negative views were not only symptoms of depression, but also preventing recovery from it.

How long does it take?

In many clinical trials, a course of standardized therapy may run up to 24 sessions; in the real world, even when more is available, the average that many patients require or desire is about six – and the biggest gains are often seen in the first two visits. (There is little evidence, in research, to support the idea that going beyond 24 sessions achieves a better result.)

How is it delivered with technology? Patients receive DVDs, booklets and online programs that give them information about their illness, symptoms to watch for and a coping strategy to practise. A big component of CBT is homework assignments. For instance, a patient may keep a journal to recognize a pattern of negative thoughts and use coping techniques to respond to them. Self-guided CBT has been found to work best when patients have the option of brief weekly contact with a therapist by phone.

Is it effective?

In a number of trials comparing CBT with medication, the therapy was been found to be equally

effective, especially for depression and anxiety. Fledgling neuroscience has shown similar effects on the brain as with medication. Drugs tend to work faster but, unlike medication, which typically must be continued to prevent relapse, CBT has also been shown to provide longer periods of recovery – up to years, according to some studies – even after sessions stop. (Psychotherapy is often recommended in combination with or as a follow-up to medication.) Researchers have argued that, despite more costs up front, this makes CBT cheaper in the long run than medication.

Why is it a common, publicly funded therapy in other countries?

CBT can be given in short doses in a number of different settings. It can be offered cheaply. Studies have found it doesn't require a psychiatrist or psychologist; it has often been as effective (and significantly cheaper) with well-trained lay people.

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