Executive Summary

Saskatchewan Mental Health Sector Study
Final Report

Prepared for the
Mental Health Workforce in Saskatchewan[1]

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by

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[1] The Mental Health Workforce referent group included representatives from:

- professional associations and regulatory bodies (College of Physicians and Surgeons of Saskatchewan, Saskatchewan Medical Association, Registered Psychiatric Nurses Association of Saskatchewan, Saskatchewan Registered Nurses' Association, Saskatchewan Association of Licensed Practical Nurses, Saskatchewan College of Psychologists, Saskatchewan Association of Social Workers, Saskatchewan Association of Occupational Therapists);
- unions (SGEU, SUN, Health Sciences Association of Saskatchewan);
- education and training programs at SIAST, SIFC, University of Regina, University of Saskatchewan;
- consumer/advocacy groups in the Saskatchewan Mental Health Advocacy Coalition (Canadian Mental Health Association, Saskatchewan Division, Alzheimer's Association of Saskatchewan, Phoenix Residential Society); and
- Saskatchewan Health (Health Human Resource Planning Team, Community Care Branch, Mental Health Advisory Council).

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Mental Health Affects All of Us

One in five people suffer from a diagnosable mental disorder in any one year, that is, about 220,000 adults and children in Saskatchewan. One in four families has at least one of its members presently suffering from a mental disorder (Chapter 1).

All of us are affected by mental health problems in our lives--by distress, anxiety or depression which while less intense or of shorter duration than a diagnosable mental disorder can hinder our work, our families, and our physical health.

It is estimated that at least one-third of family practice patients have a diagnosable mental disorder; up to 60% have no diagnosable physical disease and are suffering from primarily psychological problems. A great many patients with mental disorders and problems do not receive adequate treatment from primary care health professionals.

For our children and youth, the two most prevalent mental disorders are anxiety disorders (found in 13% of children)—youth in Canada today exhibit the highest levels of distress and anxiety in the population, when 20 years ago they had the lowest levels; and disruptive disorders (antisocial, delinquent and criminal behaviours) are exhibited by over 10% of children and adolescents. About 2-3% of young people have severe and persistent mental disorders such as autism, fetal alcohol syndrome, severe antisocial disorders, and/or substance abuse disorders.

Among our First Nations and Métis children and youth, the rates of substance abuse and suicide are very high in many communities. Many end up in the care of social services and the juvenile justice system where appropriate mental health services are not adequate.

Anxiety and depression are the most common mental disorders seen in adults, affecting 16% and 6% of adults each year respectively. Anti-anxiety and anti-depressant drugs are among the most heavily used classes of prescription drugs in the province. About 2-3% of adults are afflicted with severe and persistent mental disorders such as schizophrenia and forms of depression and bipolar disorder. Mental disorders are evident in 35-60% of our Aboriginal people with substance abuse problems.

In adults who are 65 and older, depression and severe cognitive impairments such as Alzheimer's disease, are the most prevalent mental disorders. Almost 40% of elderly who are being cared for at the primary health care level are suffering from depression. Depression in the elderly often goes undetected and untreated resulting in increased mortality from either suicide or physical illness. Adults over the age of 65 have the highest suicide rates of any age group.

Alzheimer's disease strikes 8-15% of adults over the age of 65, with rates doubling every five years thereafter. Alzheimer's and other dementias are leading contributors to the need for long-term care in the last years of life, accounting for at least one-third of long-term care residents in the province.

The Claire *Commission on Medicare* in Quebec recently identified the prevalence of violence, suicide, adjustment disorders, mental disorders, and disabilities in older adults such as Alzheimer's disease as the

problems of today and tomorrow in the health care system.

In a recent national survey, 91% of Canadians said that maintaining their mental health is "very important"; one of the highest "intense opinion" scores that COMPAS Research has ever recorded.

The Burden of Mental Illness

The burden of mental illness on health and productivity is immense. Mental illness, excluding substance abuse disorders, ranks second in the "global burden of disease" in established market economies like Canada. "Global burden of disease" is a measure that accounts for lost years of healthy life due to disability or premature death.

Mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer. Substance abuse disorders account for 6 percent of the overall burden, and when considered together with mental disorders, are the leading causes of years lost to disability or premature death.

When individual causes of disability and premature death are considered, major depression ranks 2nd only to HIV/AIDS in the world in the magnitude of disease burden for adults. The burden of depression is equivalent to that of blindness or paraplegia; schizophrenia is equal in disability burden to quadriplegia.

Conservative estimates place the costs of mental health problems (direct costs and some limited indirect costs) in the province at about $500 million per year, at a minimum.

Mental Health is at the Heart of Health Care

From the time of the Lalonde report on health promotion and illness prevention in 1975 through to the Fyke report in 2001, governments have recognized that the health of our population is determined by social and economic factors, and conditions in the physical environment. People with more education, with secure and well paying jobs, children born to middle-class families, people who live in clean environments are all healthier than their less advantaged counterparts. Investing "upstream" to improve health--in education, housing, job creation, social safety nets, public safety, and a clean environment—can prevent the need for costly health care "downstream".

Where does mental health fit in this picture of health as determined by social and environmental influences "upstream" and by physical diseases "downstream"?

Mental health is in the middle, at the heart of a holistic understanding of the effects and the causes of both the social and the physical determinants of health.

Mental health is adversely affected by poverty, unemployment, rates of violence and crime, and inadequate parenting. Such disadvantages in people's lives can lead to depression or antisocial behaviour, which in turn can lead to further social and economic disadvantage for an individual. Sometimes, a mental illness that is largely biological in nature such as schizophrenia is the cause of school failure, a life of unemployment and poverty, and premature death by suicide, accident or a physical disease. Mental health both affects and is affected by social conditions.

Mental health is also both a cause of and is affected by many physical diseases. Anxious and depressed moods, for example, initiate a cascade of adverse changes in endocrine and immune functioning that increase susceptibility to a range of physical illnesses. Few people with a condition such as heart disease or diabetes would dispute the role of stress in aggravating their condition.

Health behaviours such as diet, exercise, smoking, sexual practice, and adhering to medical therapies are all aspects of mental health or psychological well-being. Chronic congestive heart failure can be treated with surgical and pharmacological interventions; however, failure to effect change in the patient's diet, activity level, and ability to manage stress will perpetuate the factors that compromised cardiac health to begin with.

To say that mental health is at the heart of health care is to recognize that physical and mental health are deeply interdependent; and, both are affected by and have their effects on the social and economic conditions of people. Such a holistic view of health is widely appreciated today.

However, a holistic view of health often leaves decision-makers and heath providers uncertain about how to set priorities and where best to focus services. Making mental health a priority in primary health care, while not all of the solution, has several advantages.

- Mental disorders and problems are evident in over one-half of all patients seen by family physicians in primary care.
- Evidence-based, cost-effective treatments for many mental disorders and problems are available.
- Mental health interventions in primary care get at the underlying causes of many physical symptoms, can reduce utilization of more costly medical services, and can prevent the need for costly health care over the long-term.
- Mental health problems are linked to social determinants of health; mental health interventions can lead to improvements in a person's social and economic circumstances.

Mental Health Workforce: Profiles of Professionals, and Education and Training Programs

The first objective of this study of the mental health sector in the province was:

> *to compile comprehensive profiles of professionals who provide mental health services (registered psychiatric nurses, psychologists, psychiatrists, registered nurses, family physicians, licensed practical nurses, and social workers) and paraprofessionals, including data on demographics, mental health services provided, working conditions, wages, competencies, and scopes of practices; as well as an assessment of the capacity and appropriateness of education and training programs.*

Methodology. All existing data bases were searched and information compiled on each profession. A total of 48 interviews or meetings were held with key informants in professional and regulatory bodies, health districts/regions, unions, post-secondary education and training programs, and in government departments. A survey of private practitioners providing mental health services was completed.

Key issues identified for each profession and in the education and training programs are briefly summarized below (Chapter 4, and Appendices 1-8)

Mental Health Specialists

Registered Psychiatric Nurses. The Nursing Education Program of Saskatchewan (NEPS), initiated in 1996, is the training program for all students who wish to register as RNs or RPNs following graduation. NEPS replaced the diploma program in psychiatric nursing provided by SIAST (Wascana). In the past two years, as the first cohorts of students have graduated

from NEPS, only 7 new graduates have registered with the Registered Psychiatric Nursing Association of Saskatchewan (RPNAS); between 1993-97, there were an average of 43 new registrants per year with the RPNAS. The number of RPNs has decreased by 9% from 1997 to 2000 when there were 1051 RPNs active in Saskatchewan. Vacancy rates for RPN positions have increased significantly to 5.4% in 2000.

The RPNAS denied approval of the NEPS in 2001; the last class of graduates from NEPS eligible to write the RPNAS registration exam is under negotiation. The RPNAS and NEPS are currently in negotiations, facilitated by Government, with respect to the amount and quality of training in psychiatric/mental health nursing in NEPS.

A negotiated agreement is the preferred option for the continuation of RPN as a profession in the province.

RPNs are well regarded by employers, other mental health professionals, and by consumer and advocacy groups in the province. Should registered psychiatric nursing wither as a profession in Saskatchewan, ensuring adequate training and competency of sufficient numbers of RNs in mental health will be a significant challenge.

Psychologists. The shortage of psychologists in the province has been a chronic problem. There are about one-half the number of psychologists per capita in the province than the average in Canada. Vacancy and turnover rates are very high, averaging over 10% in the last decade. Shortages are greater in Regina and in rural areas; the majority of doctoral psychologists is in Saskatoon and is graduates of the clinical psychology doctoral program at the U of S.

In their workplaces, the primary concerns of psychologists are with respect to having less autonomy in practice and less recognition of their competencies than desired. A survey of psychologists in the Saskatoon Health District showed morale was poor, with concerns about lack of continuing education opportunities, lack of resources and heavy workloads, lack of career advancement, and poor communication in the workplace. Increasingly, psychologists are pursuing private practice in favour of salaried employment in the health sector.

Revitalized supply, recruitment and retention plans for psychologists are a priority. Among the preferred strategies are: increased training places for pre-doctoral interns in the program at the RUH/SDH and the development of an internship program in Regina; development of the doctoral program in clinical psychology program at U of R; increased places for doctoral students in the clinical psychology programs at U of S and U of R; development of the masters program in counseling and school psychology in the Department of Educational Psychology and Special Education at the U of S.

Psychiatrists. The shortage of psychiatrists has also been a chronic problem; there is about one-third the numbers of certified psychiatrists per capita in Saskatchewan than the average in Canada. The majority of certified psychiatrists are in Saskatoon; the shortage is greater in Regina, and the greatest in rural Saskatchewan. The total number of psychiatrists in the province (including those who are not certified and practice under special licenses, most in rural areas) has decreased from 96 in 1992 to 68 in 2001, a 29% reduction. Almost one-half of the psychiatrists in the province are over the age of 50; many will be reducing or ceasing their practices in the next decade.

A revitalized recruitment and retention plan for psychiatrists was prepared in 2001. Implementation of the plan should be a priority.

General Medical/Primary Care Sector Health Professionals

Registered Nurses. Many RNs provide mental health services in addition to those practicing in psychiatric or mental health units. In geriatric units, home care, community health, and emergency care, RNs care for a significant number of patients with mental disorders. RNs employed in these areas represent over one-third of the RN workforce in the province. Also, many mentally ill patients are cared for in general hospital units, mostly in rural areas, that are staffed by RNs and LPNs.

A holistic approach is central today in the practice of nursing, emphasizing the relationships among physical, psychological and social factors in the health of all patients. Nurses view mental health as central to the care they provide to patients in all direct care settings.

The two most critical limitations in NEPS with respect to education and training in mental health are that: 1) the curriculum only partially meets the content and skills required in the RPNAS standards and competencies; and 2) clinical training experiences are not adequate.

While NEPS does provide a good deal of training in mental health, the training can be enhanced by attention to these two limitations. The focus of the current negotiations between NEPS and the RPNAS should be on these two limitations.

As the number of RNs working in primary health care, community health, home care, and geriatric care continues to grow, as is likely, the need for competencies in mental health assessment and care will be even more important for RNs.

Competencies in mental health care should take precedence over seniority in hiring and promotion decisions for RNs and RPNs.

A broader scope of practice for RNs in primary health care will need to be more widely recognized for primary practice teams to realize their potential; still, enhanced competencies in mental health for nurse practitioners in primary care are needed.

Training of advanced nurse practitioners, at the Master's level and/or in an Advanced Certificate program, to work in primary care is recommended. Such training should incorporate mental health care.

Licensed Practical Nurses. The supply of LPNs declined by about 20% between 1990-98 and has increased slightly since then. Sixty percent of LPNs are employed in rural areas, 40% in Regina and Saskatoon. The proportion of LPNs who will retire over the next decade is greater than for RNs and RPNs.

While very few LPNs are employed in psychiatric hospitals or other mental health settings, about 16% work in geriatric care and 21% work in rural hospitals; in both settings there are a significant number of patients with mental disorders.

The number of seats for students in the diploma program in practical nursing at SIAST has been increased significantly in recent years to include seats at nine regional colleges and institutes across the province. The program is well regarded by LPNs.

Enhanced training in mental health for LPNs is desirable, particularly in long-term care. A greater number of advanced training courses are recommended.

Enhanced workplace opportunities for LPNs to work to their full scope of practice competencies are needed, particularly in long-term care; this would make more time available for RNs and RPNs to provide mental health care in acute care and long term care facilities.

Family Physicians. While the number of family physicians increased by about 6 percent between 1996-2001, there are relative shortages in rural areas, and in a recent survey a full 35% of family physicians reported that they are planning to leave practice in Saskatchewan, the highest rate of "planned departure" in the country.

The large majority of family physicians provide mental health services (psychotherapy and counseling, and prescription of psychoactive drugs). Family physicians provide about two-thirds of the physician services for mental health reasons in the province, and this is a large underestimate as it excludes many prescriptions for psychoactive drugs billed under office visits; psychiatrists provide one-third of physician services for mental health reason.

There are significant concerns about the quality of mental health services provided by family physicians in the province. For example, many foreign-trained family physicians practicing in rural Saskatchewan received no training in psychiatry. The College of Physicians and Surgeons of Saskatchewan should take measures to ensure that all general practitioners and family physicians have an acceptable level of competency in the provision of mental health services.

Family physicians do not typically have sufficient expertise in providing mental health services to their many patients.

The residency program in Family Medicine should incorporate greater training in shared care with psychiatrists and psychologists.

Continuing education opportunities and requirements in mental health services are needed.

Fee-for-service payment does not provide adequate support for the delivery of mental health services by family physicians. Alternate payment plans, particularly for primary care physicians, should be tried and tested.

The place of mental health services within a primary health care service delivery model in the province requires articulation, planning, and resources.

Human Service Sector

Social Workers. Only social workers registered with the Saskatchewan Association of Social Workers are considered in this report. The large majority have a Bachelor's or Master's degree in Social Work or Indian Social Work. Most of these social workers treat difficulties in social functioning, and provide counseling, family and marriage counseling, therapy and referral services in the mental health sector, broadly considered. Not included are most workers in the social service sector—community and social service workers (who provide social assistance and community services), probation and parole officers.

It is estimated that 50-70% of the 975 social workers registered in the SASW provide primarily mental health services. Increasingly, social workers provide mental health services privately.

The majority of graduates of the bachelors and certificate programs in social work at the U of R and SIFC do not pursue careers in mental health, and the majority does not register with the SASW.

There are two issues with respect to social workers in the mental health sector: the need for better articulated competencies with respect to the provision of direct clinical services, including a definition of the scope of practice; and the need for enhanced training in the competencies required for clinical practice in BSW and MSW programs. To address these two needs, the profession itself, that is, the SASW and post-secondary programs, must enhance their collective efforts to develop the profession of social work in the province,

particularly in the area of clinical practice and counseling.

Paraprofessionals in Mental Health

A good deal of the front line care provided to those with mental illness is being provided by paraprofessionals: staff employed by CBOs in residential care; approved home care providers; mental health therapists in rural areas and First Nations communities; addictions workers employed in the health sector; school counselors employed by school boards; recreational therapists and technologists employed in the health sector; corrections and parole workers; and several thousand aides employed in long term care facilities and in home care in the health sector.

Most, but not all, of these paraprofessionals have some training: a few will have bachelors degrees or courses in the social sciences; many will have certificates or diplomas from SIAST or SIIT (e.g., Home Care/Special Care Aide; Chemical Dependency Worker; Corrections Worker; Youth Care Worker; Community Services; Dementia Care).

Concerns about training for Home Care/Special Care Aides were raised in a recent labour market study for Government. In particular, there are needs for: greater emphasis on orientation, training and professional development offered by health districts; improvements in the availability, cost and the quality of certificate programs offered by SIAST at SIIT; and enhanced continuing training opportunities and funding.

Private Practice Sector in Mental Health

Private mental health services are increasingly being provided, mainly by social workers and psychologists, and by unregulated therapists/counselors. About 250 individuals advertise mental health services in the yellow pages in Saskatchewan (under Counseling, Marriage and Family Counselors, Psychologists, Social Workers and other headings).

About one-third of their income is from client private insurance coverage (mostly Employee Assistance Programs); about one-fourth directly from client, out-of-pocket, payment; about 20% is derived from Saskatchewan Government contracts (Social Services, SGI, WCB and other departments/agencies). Average hourly fees are $75.00.

It is estimated that private mental health services amount to about $12 million annually in the province; over 150,000 hours of private services are provided each year.

Is it desirable that mental health services are increasingly available for those who can afford private services while public mental health services are increasingly difficult to access? This question merits consideration as health policies are reviewed and revised in the coming years.

Mental Health Services

The second objective of this study of the mental health sector was:

> *to review issues, needs and gaps in mental health services and recommend how client needs may be more effectively met through enhancements in the workforce and the workplace.*

Evidence-Based Treatment Programs

A review of the world literature on the treatment of mental disorders and problems was completed: treatment programs for children and youth, adults, and older adults (Chapter 3). A recent report on mental health by the U.S. Surgeon General offers two important conclusions based on an extensive review:

1.) The efficacy of mental health treatments is well documented.

2.) A range of effective treatments exists for many mental disorders.

Drugs that control the symptoms of many mental disorders are available and widely prescribed. Many are expensive and not used by individuals who do not qualify for the provincial drug plan and do not have private insurance. For instance, antidepressants such as the selective serotonin reuptake inhibitors cost about $130 per month for an average dosage.

Among the range of effective psychological treatments are:

- behavioural programs for parents and children with AD/HD, disruptive disorders, and anxiety disorders;
- multisystemic therapy for youth with antisocial disorders and substance abuse;
- cognitive-behavioural therapy for adults suffering from anxiety and depression;
- assertive community treatment programs for severely and persistently mentally ill adults.

Mental Health Treatment Programs And Services in Saskatchewan

The availability of evidence-based treatment programs in mental health is extremely limited in the province (Chapters 2 and 3). Given the chronic shortages of mental health specialists in Saskatchewan it could not be otherwise.

Psychiatrists and psychologists have the specialty knowledge and skill that is required to design and implement effective treatment programs. They are needed to train and supervise nurses, social workers, family physicians and paraprofessionals who will deliver the treatment programs. Without such mental health specialists to help lead the way and guide others, effective treatment programs and services are not possible.

Mental health specialists and services are most critically needed in the following areas:

- child, youth and family, and services in schools;
- geriatric, and services in long term care and home care;
- forensic, and services in corrections settings;
- addictions and mental health;
- community care of the severely and persistently mentally ill;
- community care of the intellectually disabled;
- Aboriginal mental health and community development;
- primary health care.

Public Education and Mental Health Promotion

The majority of people with a mental health disorder or problem do not seek treatment from a health professional. The stigma that surrounds mental health problems and treatment is a major barrier to improved mental health for people. In a recent survey, only 54% of Canadians indicated that they would want a friend to know that they were receiving counseling or treatment for depression.

Programs of public education to increase awareness of mental health problems and services are needed. Programs that promote positive mental health are needed. Such programs should be available in day cares, schools, workplaces, churches, health care and social services settings.

The Voluntary Sector and Informal Care

Consumers of mental health services have consistently told us that what contributes to their recovery as much as formal services is the care and support from family, friends and community, and from other consumers. There is no question that such support is critical, essential for most people.

Resources for consumer self-help and advocacy groups, and programs for families and friends of the mentally ill who are their caregivers are very limited in the province.

Investments in voluntary and informal supports are equally as important as investments in formal mental health services. The returns are likely to be great when measured in terms of the quality of life of the mentally ill in Saskatchewan, where our relative isolation, rural and Northern population, Aboriginal population, chronic shortages of professionals, and economic constraints all conspire to limit the prospects for building the kind of high quality specialty mental health sector that most professionals desire. For example, investing in mental health professionals who can do the community development work required to initiate and sustain voluntary and informal support networks is likely to yield very significant returns.

Making Mental Health a Priority

The key issues identified in this report—chronic shortages of mental health specialists, and serious inadequacies in services—are not new. Nor are the recommendations offered new. A number of reports by Government, Health Districts/Authorities, professional associations, and community advocacy groups have identified the same issues and offered similar recommendations.

Mental Health is not a priority in Health. For example, Mr. Fyke mentions mental health in passing with a familiar observation: “it has long been recognized that mental illness gets short shrift in our current system”. Mental health receives about 3.5% of the total Health budget, and about 3.8% of spending by Districts/Authorities; the share of Health expenditures for mental health has been decreasing in the past five years as expenditures in acute health care have increased.

Nor is mental health a priority in Social Services, Corrections and Learning where the mental health needs of the people served are very significant.

Why is mental health not a priority in Health and the human service sector? The simple answer is that the stigma that remains attached to mental health problems means that there are no advocates for mental health in our Health Districts/Authorities, or social services, or corrections services, or schools. There are no advocates for mental health in the constituencies that elect our politicians.

Those with mental disorders, 20 percent of Saskatchewan people every year, are invisible or "forgotten constituents" (the title of a 1983 report by the CMHA, Saskatchewan Division).

Making mental health a priority requires leadership by the Government of Saskatchewan. The *Action Plan for Saskatchewan Health Care* speaks of mental health needs, particularly in primary care.

The Quality Council in Health should address mental health as a priority issue. It should: establish indicators for population mental health, monitor these and report regularly; and monitor access to evidence-based mental health treatments.

A provincial mental health human resource plan should be developed by the Health Human Resources Council.

Enhanced integration of mental health and addictions services is a long standing issue that must be seriously addressed.

Mental health specialists (psychiatrists, psychologists, RPNs) must be well integrated into primary care service delivery teams, and also in pediatrics, long term care, home care, and community care services.

Given the chronic need for mental health professionals, government funding to the two universities that is targeted to the training of key mental health professionals, as is done for nursing and medicine, is recommended.

Government, regional health authorities, professional associations and regulatory bodies, along with post-secondary institutions must all commit themselves to addressing the critical need for continuing and advanced education for all mental health professionals and paraprofessionals. Collaborative, cost-shared continuing education programs in mental health that are interdisciplinary are desirable, that is, programs designed for and accessed by a number of professions.

Significant incremental funding for mental health is required, funding in Health, Learning, as well as in Social Services, Corrections, and Learning.

In order for priority to be given to advancing a revitalized mental health agenda in Saskatchewan, it is recommended that an intersectoral committee of Assistant Deputy Ministers be established.

Stakeholders for this study included representatives from professional associations and regulatory bodies, unions, education and training programs at the three universities and SIAST, and consumer and advocacy groups. Their input is reflected in every aspect of the study.

The Mental Health Workforce Stakeholders will continue their work to ensure that recommendations in this Final Report are acted upon. A Letter of Intent was submitted on August 12, 2002 to Health Canada, Primary Health Care Transition Fund, for national envelope funding for a project, *Primary Health Care Approaches for Anxious and Depressed Populations*