Saskatchewan Mental Health Sector Study

Final Report

Prepared for the

Mental Health Workforce in Saskatchewan

Funded by
Saskatchewan Learning
in partnership with
Saskatchewan Health

by

John Conway

August 2002
January 2003 (updated*)

* The Final Report was updated in January 2003 to reflect Collective Bargaining Agreements signed between SAHO and SUN, April 2002; and between SAHO and the Health Sciences Association of Saskatchewan, November 2002.

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Executive Summary

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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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Executive Summary

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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 have 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 databases 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.*

Saskatchewan Mental Health Sector Study

Introduction

This study of the mental health sector and its workforce was completed for the Mental Health Workforce in Saskatchewan and funded by the Department of Learning (Job Start/Future Skills, Sector Partnerships Component) in partnership with the Department of Health (Health Workforce Planning Team).

Terms of Reference

The terms of reference for the study, as per the contract, were to develop a profile of the current mental health workforce in Saskatchewan that includes:

- demographics, employment sectors, type of services provided, and client's served;
- wages/benefits comparisons to other Western provinces;
- comparisons of licensing and regulations, and unionization;
- an assessment of the appropriateness and capacity of current education and training programs;
- an assessment of the scopes of practices and client services provided by each profession and a determination if services are being provided by the most appropriate health provider;
- comparisons of working conditions, turn over rates and vacancies with other Western provinces;
- information about the extent of private practice provided by mental health practitioners outside of the public health sector.

And, to review issues, needs and gaps in the mental health system:

- provide an overview of the current and emerging mental health issues and needs in the province;
- identify how mental health needs are currently being met and where service and client group gaps exist;
- examine how client needs may be more effectively met, through consideration of revitalized recruitment and retention practices, expanded or modified scopes of practice, and new service delivery approaches;
- develop strategies that will address how to better meet client needs and improve the workplace environment for mental health workers in the province.

Introduction to the Final Report

An Overview of Mental Health is provided in Chapter One: what mental illness is, how it is understood as caused by a combination of biological, psychological and sociocultural determinants, the prevalence of mental disorders and the economic and social burden of mental disorders.

In Chapter Two, the Mental Health System is described. The four sectors that make up the patchwork of the mental health system in Saskatchewan are reviewed: specialty mental health services; general

medical/primary care services; the broad human service sector; and the voluntary sector and informal care and support for mentally ill.

An Overview of Evidence-Based Mental Health Treatment Programs is provided in Chapter Three. Effective treatments for major mental disorders in children and youth, adults and older adults are reviewed.

In Chapter Four, comprehensive profiles of seven professions (RPNs, psychologists, psychiatrists, RNs, LPNs, family physicians, social workers) and paraprofessions providing mental health services in the province are provided: supply, demographics, competencies and scopes of practice, working conditions and wages, and mental health services provided. Education and training programs in each profession are reviewed. Issues in each of the professions are identified.

Finally, in Chapter 5, key issues are summarized and recommendations offered.

Methodology

A review of the literature on mental health systems and services, and on evidence-based treatments for mental disorders was done, relying on two recent and important reports on mental health by the World Health Organization (2001) and the U.S. Surgeon General (1999).

Interviews and meetings (48) were held with key informants in professional associations, regulatory bodies, unions, post-secondary education and training programs, and government. These are listed in Appendix 10.

Comprehensive profiles for each mental health profession were compiled based on searches of all relevant available databases and information provided by professional associations, regulatory bodies, unions, post-secondary education and training programs, and government sources. Data sources are listed in Appendix 9.

A survey of private practitioners providing mental health service was conducted (Appendix 8).

Stakeholder Group[1]

Stakeholders in the mental health sector met on five occasions during this study, providing feedback and advice on each chapter in the Final Report. Their recommendations are reflected throughout this report. The stakeholder group will continue to work together to ensure that the recommendations offered in the Final Report are implemented.

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[1] The stakeholder/referent group includes 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; and representatives from 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 (Community Care Branch, Mental Health Advisory Council).

Chapter One

An Overview of Mental Health

Mental health has long been recognized as integral to the health and well-being of people.

> In the Preamble to its Constitution the World Health Organization (WHO) defines health as "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".
>
> In *The Commission on Medicare*, Mr. Justice Emmett Hall, nearly 40 years ago now, identified mental illness as the problem of greatest public concern.
>
> The *Canada Health Act* identifies that the primary objective of Canadian health care policy is "to protect, promote and restore the physical and mental well-being of residents of Canada" (Clause 3).
>
> The Claire *Commission on Medicare* in Quebec recently identified the emergence 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.
>
> *The Action Plan for Saskatchewan Health Care* places a priority on enhancing access to primary health care, which is defined as covering "everything from the diagnosis of common illnesses to the treatment of minor injuries and the management of ongoing problems like asthma, diabetes, high blood pressure, or anxiety".

Such recognition of mental health has, however, never been accompanied by adequate resources for mental health services. In the recent report of the Commission on Medicare, 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 illness, mental disorders, and mental health problems

Mental illness is the term that refers collectively to all diagnosable mental disorders. *Mental disorders* are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression is a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder is an example of a mental disorder largely marked by alterations in behavior (over activity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior contribute to a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (American Psychiatric Association, 1994).

This report uses the term *mental health problems* for signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder. Almost everyone has experienced mental health problems in which the distress one feels matches some of the signs and symptoms of mental disorders. Mental health problems may warrant active efforts in health promotion, prevention, and treatment.

Bereavement in older adults is an example of a mental health problem warranting intervention. Bereavement symptoms of less than 2 months' duration do not qualify as a mental disorder, according to professional manuals for diagnosis (American Psychiatric Association, 1994). Nevertheless, bereavement symptoms can be debilitating if they are left unattended. They place older people at risk for depression, which, in turn, is linked to death from suicide, heart attack, or other causes (Zisook & Shuchter, 1991, 1993; Frasure-Smith et al., 1993, 1995; Conwell, 1996). Much can be done—through formal treatment or through support group participation—to ameliorate the symptoms and to avert the consequences of bereavement. In this case, early intervention is needed to address a mental health problem before it becomes a potentially life-threatening disorder.

Understanding Health and Mental Health

While the precise causes of most mental disorders and problems are not known, the broad forces that shape them are known: these are biological, psychological, and social/cultural factors.

It is important to keep in mind that the causes of health and all disease, physical and mental, are generally viewed as a product of the interplay or interaction between biological, psychological, and sociocultural factors. For instance, diabetes and schizophrenia alike are viewed as the result of interactions between biological, psychological, and sociocultural influences. With these disorders, a biological predisposition, or vulnerability, is necessary but not sufficient to explain their occurrence (Barondes, 1993). For other disorders, a psychological or sociocultural cause may be necessary, but again not sufficient.

Such a ***biopsychosocial*** model for understanding health and mental health disorders fits with common experience. Few people with a condition such as heart disease or diabetes, for instance, would dispute the role of stress in aggravating their condition. Research bears this out and reveals many other relationships between stress and disease (Cohen & Herbert, 1996; Baum & Posluszny, 1999).

Mental and physical health are closely interwoven and deeply interdependent. There are two main pathways through which mental and physical health mutually influence each other (WHO, 2001). Physiological systems, such as neuroendocrine and immune functioning, are one pathway. 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. Health behaviour is another pathway and concerns activities such as diet, exercise, sexual practice, smoking, and adhering to medical therapies. The health behaviour of an individual is highly dependent on that person's mental health. For example, adolescents that are depressed or abuse substances are more likely to engage in smoking and high-risk sexual behaviour. And, chronic congestive heart failure can be treated with a combination of 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.

The link between mental and physical illnesses is sometimes indirect and complex. A good example is the relationship between tobacco use and mental disorders. People with mental

disorders are about twice as likely to smoke as others. It is estimated that about 44% of all cigarettes smoked in the U.S. are consumed by people with mental disorders (Lasser et al., 2000). Regular smoking starts earlier in male adolescents with attention deficit disorder (Castellanos et al., 1994**)**, and individuals with depression are also more likely to be smokers (Pomerleau et al., 1995). A study of teenagers showed that those who became depressed had a higher prevalence of smoking beforehand, suggesting the possibility that smoking may have some causal role in depression among adolescents (Goodman & Capitman, 2000). Neurochemical mechanisms likely account for part of the relationship between smoking and mental disorders. Nicotine has highly reinforcing chemical effects in the brain, and leads to increased dopamine release in parts of the brain also related to mental disorders such as depression.

As is well documented, social factors such as poverty and associated conditions of unemployment, low educational level, and deprivation also have important effects on mental health as well as physical health. A review of 15 studies found the median ratio for overall prevalence of mental disorders between the lowest and the highest socioeconomic categories was 2:1 for one-year prevalence (Kohn et al., 1998). There is also good evidence that the course of disorders is determined by the socioeconomic status of the individual (Kessler et al., 1994; Saraceno & Barbui, 1997). This is partly a result of service-related barriers, particularly barriers to accessing care. The treatment gap for most mental disorders is large, but for the poor it is massive. The vicious, intergenerational cycle of poverty and mental disorders at the family level can also be found in whole communities, as is sadly the case in some of our First Nations communities in the province.

One single factor in isolation—biological, psychological, or social—may weigh heavily or hardly at all, depending on the mental health problem. That is, the relative importance or role of any one factor in causation often varies. For example, schizophrenia is linked strongly to genetic factors, according to twin studies. But this does not mean that genetic factors completely determine the nature of the disorder and that psychological and social factors are unimportant. These psychological and social factors modify expression and outcome of disorders. Likewise, some mental disorders, such as post-traumatic stress disorder (PTSD), are clearly caused by exposure to an extremely stressful event, such as rape or being a victim of other violent acts (Yehuda, 1999). Yet not everyone develops PTSD after such exposure. On average, about 9 percent do (Breslau et al., 1998), with estimates higher for particular types of trauma. For women who are victims of crime, one study found the prevalence of PTSD in a representative sample of women to be 26 percent (Resnick et al., 1993). The likelihood of developing PTSD is related to pretrauma ***vulnerability*** (in the form of preexisting genetic, biological, and personality factors), magnitude of the ***stressful event***, preparedness for the event, coping skills, and the quality of care after the event (Shalev, 1996).

Most mental disorders and problems are understood as caused by the combination of vulnerability (a biological and/or psychological predisposition to develop any particular disorder) and stressful events that overtax an individual's abilities to cope. The increase in mental health problems, as well as in many physical illnesses, that are seen among rural and farm families in Saskatchewan during times of significant economic hardship in agriculture provides an illustration of the **vulnerability-stress model** in the development of mental health problems and disorders. Farming is one of the ten most stressful occupations even in the best of times. During economic downturns in the agriculture sector, as the stresses of farming increase so does the incidence of mental illnesses for those with vulnerabilities for particular disorders. During the present "farm crisis", there are increased risks for depression, suicide, substance abuse, marital discord and disruption, domestic violence, adjustment problems and antisocial behaviour in children and youth due to family dysfunction and poor parenting, and increased risk for farm accidents and

injury (Beeson, 1999). The Farm Stress hotline in Saskatchewan has averaged about 1400 calls in recent years, a high of 1700 calls in 1998.

Prevalence of mental illness

Few families in the province are untouched by mental illness. It is estimated that one in four families has at least one of its members currently suffering from a mental disorder (WHO, 2001). According to the best epidemiological estimates from the United States (as cited by the U.S. Surgeon General, 1999) and the World Health Organization (2001), at least one in five people has a diagnosable mental disorder during the course of a year (i.e., one-year prevalence), that is, about 220,000 people in the province.

These estimates are based on studies of the highest quality available in the world today. In the absence of equivalent Canadian research, these epidemiological studies have been used by researchers and policy makers in Canada (e.g., Bland, 1998; Bland et al., 1988; CMHA-Ontario Division, 1998; Offord et al., 1996) and are used in this report to estimate the prevalence of mental disorders in Saskatchewan.

The prevalence estimates reported below are alarming to many people. Most mental health professionals, however, expect that mental health problems are likely to increase in the years ahead, in tandem with trends that demonstrate increases in child poverty, income disparities, involuntary part-time work, single parenting, youth unemployment, and increases in the numbers of our Aboriginal peoples who are troubled and marginalized; and in tandem with declining expenditures in social, educational, and mental health services.

Adults. The current prevalence estimate is that about 21 percent the adult population is affected by mental disorders during a given year. In general, 19 percent of adults have a mental disorder alone (in any one year); 3 percent have both mental and addictive disorders; and 6 percent have addictive disorders alone. Consequently, about 28 to 30 percent of the population has either a mental or addictive disorder (Regier et al., 1993b; Kessler et al., 1994). Table 1 summarizes the best one-year prevalence estimates for major mental disorders from U.S. epidemiological research, as reported by the U.S. Surgeon General (1999).

Table 1. ***Best estimate one-year prevalence rates for adults (ages 18-54), U.S. Surgeon General (1999)***

	Best Estimate Prevalence (%)
Any anxiety disorder	16.4
Any mood disorder	7.1
Schizophrenia	1.3
Non affective psychosis	0.2
Somatization	0.2
Antisocial personality disorder	2.1
Anorexia nervosa	0.1
Severe cognitive impairment (mental retardation, dementias)	1.2
Any disorder	21.0

Individuals with co-occurring mental disorders and addictions (about 3 percent of the adult population) are more likely to experience a chronic course and to utilize services than are those with either type of disorder alone. Clinicians, program developers, and policy makers need to be aware of these high rates of co-morbidity—about 15 percent of those with a mental disorder in one year (Regier et al., 1993a; Kessler et al., 1996).

Based on data on functional impairment, it is estimated that 9 percent of all adults have one or more of the mental disorders listed in Table 1 and also experience some significant functional impairment (U.S. National Advisory Mental Health Council, 1993). Most (7 percent of adults) have disorders that persist for at least one year (Regier et al., 1993b). A subpopulation of 5.4 percent of adults is considered to have a "serious" mental illness (SMI) (Kessler et al., 1996); serious mental illness generally applies to mental disorders that seriously interfere with some area of social functioning.

About half of those with SMI (or 2.6 percent of all adults) are identified as being even more seriously affected, that is, by having "severe and persistent" mental illness (SPMI) (NAMHC, 1993; Kessler et al., 1996). This category includes schizophrenia, bipolar disorder, and other severe forms of depression, panic disorder, and obsessive-compulsive disorder. It is estimated that over 24,000 adults (18 years of age and older) in Saskatchewan suffer from a severe and persistent mental illness (Health Systems Research Unit, 1997)

Children and Adolescents. The annual prevalence of mental disorders in children and adolescents is not as well documented as that for adults. About 21 percent of children are estimated to have mental disorders with at least mild functional impairment (see Table 2). A sub-population of children and adolescents with more severe functional limitations may be considered to have a "serious emotional disturbance" (SED). Children and adolescents with SED number approximately 5 to 9 percent of children ages 9 to 17 (Friedman et al., 1996).

Table 2. ***Best estimate one-year prevalence children and adolescents ages 9-17 with mental or addictive disorders and at least mild global impairment (U.S. Surgeon General, 1999)***

	Best Estimate Prevalence (%)
Anxiety disorders	13.0
Mood disorders	6.2
Disruptive disorders	10.3
Substance abuse disorder	2.0
Any disorder	20.9

Not all mental disorders identified in childhood and adolescence persist into adulthood, even though the prevalence of mental disorders in children and adolescents is about the same as that for adults (i.e., about 21 percent of each age population). While some disorders do continue into adulthood, a substantial fraction of children and adolescents recover or "grow out of" a disorder, whereas, a substantial fraction of adults develop mental disorders in adulthood.

A striking Canadian finding is that youth now exhibit the highest distress levels in the population in recent national health surveys, when they had the lowest levels of distress 20 years ago (Stephens et al., 1999; Stephens, 1998). This trend raises the serious possibility of lifelong mental health problems for the current youth cohort.

Older Adults. The annual prevalence of mental disorders among older adults (ages 55 years and older) is also not as well documented as that for younger adults. Estimates indicate that about 20 percent of the older adult population has a diagnosable mental disorder during a one-year period (Table 3). Almost 4 percent of older adults have SMI, and just under 1 percent has SPMI (Kessler et al., 1996). These figures do not include individuals with severe cognitive impairments such as Alzheimer's disease.

Table 3. ***Best estimate one-year prevalence rates for older adults (age 55+), U.S. Surgeon General (1999)***

	Best Estimate Prevalence (%)
Any anxiety disorder	11.4
Any mood disorder	4.4
Schizophrenia	0.6
Somatization	0.3
Antisocial personality disorder	0
Severe cognitive impairment (Alzheimer's, other dementias)	6.6
Any disorder	19.8

Depression is very common among the elderly over age 70: studies show that 8-20% being cared for in the community and 37% being cared for at the primary health care level are suffering from depression (WHO, 2001). Depression is more common among older people with physically disabling disorders (Katona & Livingston, 2000). The presence of depression further increases the disability among the elderly. Depressive disorders among the elderly go undetected even more often than among younger adults because the symptoms are often mistakenly considered a part of the ageing process.

The Stigma of Mental Illness

Between 60-65% of all people with diagnosable mental disorders do not seek treatment (Regier et al., 1993; Kessler et al., 1996, Stephens & Joubert, 2001). Stigma surrounding the receipt of mental health treatment is the major barrier that discourages people from seeking treatment (Sussman et al., 1987). Concern about stigma appears to be heightened in rural areas relative to larger towns or cities (Hoyt et al., 1997). Stigma also disproportionately affects children and older adults to a greater extent than adults.

In a 2001 COMPAS survey, only 54% of Canadians surveyed indicated that they might want a friend to know that they were receiving counseling or treatment for depression. According to CMHA National President, Bill Gaudette, "Changing attitudes to mental illness continues to be our biggest challenge. Discrimination, ignorance and fear remain the enemies that we have to conquer" (CMHA, 2001b).

The Burden of Mental Illness

The burden of mental illness on health and productivity has long been profoundly underestimated. Data developed by the massive Global Burden of Disease study (Murray & Lopez, 1996), conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide, ranks second in the burden of disease in established market economies, such as Canada (Table 4).

Table 4. ***Disease burden by selected illness categories in established market economies, 1990 (WHO, 2001)***

	Percent of Total DALYs*
All cardiovascular conditions	18.6
All mental illness (includes suicide)	15.4
All malignant diseases (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious & parasitic diseases	2.8
All drug use	1.5

* Disability-adjusted life year (DALY) is a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration.

Mental illness emerged from the Global Burden of Disease study as a surprisingly significant contributor to the burden of disease. The measure of calculating disease burden in this study, called Disability Adjusted Life Years (DALYs), allows comparison of the burden of disease across many different disease conditions. DALYs account for lost years of healthy life regardless of whether the years were lost to premature death or disability. The disability component of this measure is weighted for severity of the disability.

For example, major depression is equivalent in burden to blindness or paraplegia, whereas active psychosis seen in schizophrenia is equal in disability burden to quadriplegia.

Recent estimates from Australia place mental disorders as the leading cause today of disability burden (Vos & Mathers, 2000). Taking the disability component of burden alone (i.e., excluding the premature death component), 2000 estimates show that all mental illnesses account for 31% of all years lived with disability due to disease in the world (WHO, 2001).

Major depression ranks second only to HIV/AIDS in the world in the magnitude of disease burden for adults (Table 5). Alcohol use disorders, self-inflicted injuries, schizophrenia, bipolar affective disorder, and panic disorder also ranked among the 20 leading sources of disability-adjusted life years in adults in the world. Using a somewhat different measure of disease burden (i.e., years of life lived with disability) several additional mental disorders are considered leading causes of disease burden: Alzheimer's disease and other dementias, migraine, drug use disorders, and obsessive compulsive disorder.

Table 5. ***Leading world-wide causes of disability-adjusted life years (DALYs) in adults (age 15-44), WHO, 2001***

	Percent of Total DALYs *
1. HIV/AIDS	13
2. Unipolar depressive disorder	8.6
3. Road traffic accidents	4.9
4. Tuberculosis	3.9
5. Alcohol use disorders	3.0
6. Self-inflicted injuries	2.7
7. Iron-deficiency anemia	2.6
8. Schizophrenia	2.6
9. Bipolar affective disorder	2.5
10. Violence	2.3
11. Hearing loss, adult onset	2.0
12. Chronic obstructive pulmonary disease	1.5
13. Ischemic heart disease	1.5
14. Cerebrovascular disease	1.4
15. Falls	1.3
16. Obstructed labour	1.3
17. Abortion	1.2
18. Osteoarthritis	1.2
19. War	1.2
20. Panic disorder	1.2

Economic costs in Canada. The economic impact of mental disorders is wide ranging, long lasting and huge. Health Canada (1993), in its report *Economic Burden of Illness in Canada*, estimated that the direct and indirect costs of mental disorders at $7.8 billion in 1993; mental disorders ranked seventh among the 20 disease categories for which estimates were published.

Recent work has addressed some of the methodological limitations of Health Canada's estimate (Stephens & Joubert, 2001). Direct costs include hospital care, other institutional care, physician care, prescription medications, and care by psychologists and social workers in the private sector. Indirect costs include short-term sick days, long-term disability, and premature death.

Based on refinements of both direct and indirect cost estimates, the total economic burden of mental health problems in Canada is now estimated at $14.4 billion, at a minimum, for 1998 (Stephens & Joubert, 2001). Mental disorders are among the highest cost disease categories in the country. In Saskatchewan, based on the province's population (3.3% of the Canadian population), the total economic burden of mental disorders can roughly be estimated at $475 million annually in 1998 dollars, at a minimum.

These estimates of economic costs are conservative, considerably lower than estimates based on the Global Burden of Disease data of the World Bank and WHO. These economic estimates for Canada and Saskatchewan do not include the direct costs for children under age 12, alcohol and substance abuse, severe and persistent mental illness, and Alzheimer's disease; direct costs for counseling by a variety of other professionals, paraprofessionals, and in schools are not included, nor are community based services provided by CBOs. More importantly, the considerable indirect costs of social services, housing, education, justice and corrections services are not included in these economic cost estimates. Further, the low treatment costs in many regions because of lack of professionals and access to treatment, including in rural Saskatchewan, in all likelihood increase the indirect costs by increasing the duration of untreated disorders and associated disability (Chisholm et al., 2000).

Economic cost estimates from other countries, which include some of the direct and indirect costs that are excluded in Canadian estimates, suggest the total economic burden of mental disorders is certainly much greater than $14.4 billion in Canada. For example, in the U.S., the aggregate yearly cost of mental disorders has been estimated at 2.5% of gross national product (Rice et al, 1990).

Impact on the quality of life. In addition to disability-adjusted life years lost, mental disorders and problems cause enormous unhappiness and suffering that has been captured using quality of life measures (Lehman et al., 1998). Studies using such measures show that the negative impact of mental disorders is not only substantial but sustained (UK700 Group, 1999). Quality of life continues to be poor even after recovery from mental disorders as a result of social factors that include continued stigma and discrimination. Unmet basic social and everyday functioning needs appear to be most closely associated with poor quality of life among those with severe mental disorders (UK700 Group, 1999). Anxiety and panic disorders also have a major negative impact on quality of life, in particular with regard to psychological functioning (Mendlowicz & Stein, 2000).

Mental Health of First Nations and Métis peoples. The mental health of Saskatchewan's First Nations and Métis peoples is considered separately here and in Chapter 2 for several reasons. First, the mental health issues of First Nations and Métis peoples are very significant and complex, are critical given the large numbers of Aboriginal people in the province, and Aboriginal mental health remains a neglected area of research and practice. While treating First Nations and Métis peoples separately in this report may help to focus attention on the pressing needs, more is required. A separate study focusing on policy and programming for Aboriginal mental health in Saskatchewan, in partnership with Aboriginal people, is warranted.

Second, the European colonization of indigenous peoples of Canada is a history of systematic suppression and dislocation, a story of cultural genocide. The origins of much of the distress and mental health problems we see today among First Nations and Métis peoples is a result of this long history of oppression and abuse, a legacy of colonization that continues today with marginalization and absorption into a global economy with little regard for their autonomy. The cultural dislocation suffered by First Nations and Métis peoples must be recognized as the primary cause of the high rates of alcoholism, depression, suicide and violence in many communities (e.g., Waldram, 1997; York, 1990). The striking parallels in the mental health problems of indigenous peoples around the world suggests there are common social, political and economic processes at work (e.g., Hunter, 1993; Kirmayer, et al., 2000; Kunitz, 1994).

Many Aboriginal leaders in the province do not consider alcoholism, depressions, suicide and violence to be "mental health" problems. Rather, they view such difficulties as the direct results of colonial oppression. Thus, understanding mental illness among Aboriginal peoples requires significant revision of our European biopsychsocial models of mental illness.

Third, mental health services for Aboriginal peoples are considered separately in Chapters 2 because of the growing appreciation that Aboriginal realities, values and aspirations require that conventional models of mental health treatment services also be rethought, abandoned sometimes. Chaimowitz (2000) puts the challenge well: "To conceptualize Aboriginal mental health as an area in which we deliver culturally sensitive service to a disadvantaged population would be simplistic and wrong; the potential for falling into the trap of a more modern version of paternalistic intervention is high" (p. 606).

Cultural sensitivity and "evidence-based" treatment are not enough; our best professional efforts may cause more harm than healing. Healing must come from and be embedded within the local culture of Aboriginal communities, local control of health and mental health systems are needed (as is the case in many of the 121 Saskatchewan programs funded to date by the Aboriginal Healing Foundation). The mental health of individuals is linked to the health of Aboriginal communities and their sense of local control and cultural continuity.

Ultimately, political efforts to restore Aboriginal rights, settle land claims, and redistribute power through various forms of self-government hold the keys to healthy communities (Kirmayer, et al., 2000; Warry, 1998). Many Aboriginal leaders in Saskatchewan consider these political efforts, and not "mental health" interventions, as the real solutions. Hence, many are reluctant to implement "mental health" interventions per se.

An important study by Chandler and Lalonde (1998) may be cited as demonstrating a clear link between community control or autonomy and mental illness among Aboriginal peoples, suicide rates in this study. Indicators of what the authors called "cultural continuity", or local control, were examined across 196 bands in British Columbia: community control of police and fire services, education, health, local facilities for cultural activities, self-government, and

involvement in land claims. A strong relationship was found between these indicators of "cultural continuity" and suicide rates: the greater the extent of local community control, the lower were the suicide rates across these communities.

Prevalence of mental illness among Aboriginal children and youth. The Canadian Institute on Child Health has argued that Aboriginal children are "among the most disadvantaged of all Canadians" (see Stout & Kipling, 1999 for documentation of the information bulleted below unless otherwise referenced).

- The infant mortality rate for First Nations babies is roughly twice the Canadian average.

- Nine percent of First Nations mothers are under 18 years of age (compared to one percent for Canadian mothers in general); on-reserve, the rate of pregnancy in First Nations females under the age of 15 is about eighteen times higher than in the general Canadian population (11/1000 live births compared to 0.6/1000) (First Nations and Inuit Health Branch, November, 1999).

- A Saskatoon study of pregnant women found that health risk behaviours (alcohol intake, tobacco use, use of psychoactive drugs, caffeine intake) during early pregnancy were more prevalent among Aboriginal women (Godel, et al., 1992). Parental exposure to alcohol can cause intellectual deficits, learning disabilities, hyperactivity, attention and/or memory deficits, inability to manage anger, and difficulties with problem solving—all symptoms of FAS or FAE.

- Disorders of the nervous system were found to be common reasons for the use of medical services in Aboriginal children up to the age of 14 in the Prairies (First Nations and Inuit Health Branch, November, 1999). This may in part reflect the effects of exposure to alcohol and environmental contaminants in utero.

- The incidence of Fetal Alcohol Syndrome (FAS) appears to be much higher in some Aboriginal communities that in other parts of Canada (Ashley, 1994; McKenzie, 1997). A study of a First Nations reserve in Manitoba reported that 1 in 10 children was the victim of FAS or FAE (Fetal Alcohol Effect), or roughly 100 cases per 1000 births (Square, 1997). This rate is extraordinarily high, however. Local research (Habbick et al., 1996), using very conservative diagnostic criteria for FAS (and not FAE) estimates a rate of 0.585 per 1000 live births. In comparison, the rate of FAS in western countries is about 0.33/1000 births (McKenzie, 1997).

- First Nations youth are at elevated risk of suffering from a physical, developmental or learning disability, with one regional study going so far as to suggest that Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) are responsible for nearly 75 percent of these cases.

- Levels of morbidity and mortality among Indian children and youth remain high throughout their first 18 years of life. Contributing factors include an injury rate three times the national average; along with rates of suicide, depression and childhood sexual or physical abuse that are deemed to be significantly higher than those of the non-Aboriginal population.

- There are nearly twice as many families on-reserve led by a single parent (24 percent) than is the case elsewhere in Canada (where the rate is 13 percent). Lone and teenage parent families tend to experience high rates of poverty and marginalization.

- First Nations children being taken into foster care at well over four times the rate of non-Aboriginal children.

- A high proportion of First Nations youth (64 percent) never complete high school. By contrast, only 31 percent of non-Aboriginal Canadians fail to obtain a secondary school diploma.

While research on Aboriginal children's mental health is quite limited, there is clear evidence of very high rates of substance abuse and suicide among adolescents in many communities (Beiser & Attneave, 1982; Gotowiec & Beiser, 1994).

Aboriginal youth are at two to six times higher risk for every alcohol related problem than their non-Aboriginal counterparts in the Canadian population (First Nations and Inuit Health Branch, November, 1999). One in five Aboriginal youths has used solvents and one-third of users is under the age of 15. Over half began to use solvents before reaching 11 years of age (Health Canada, First Nations and Inuit Health Branch, November, 1999). Almost one-half of a sample of Alberta Aboriginal students from grades 5 to 12 were problem gamblers or at risk of becoming one (Health Canada, First Nations and Inuit Health Branch, November, 1999).

Canadian First Nations and Inuit peoples have a suicide rate that in 1997 was up to almost three times higher than the rate for the total Canadian population. In Saskatchewan, the age-standardized suicide rates for First Nations were considerably lower, at 19/100,000 compared to a rate of 13/100,000 in the total Canadian population (Health Canada, First Nations and Inuit Health Branch, November, 1999). Suicide rates are highly variable across First Nations communities (Kirmayer, 1994). The risk factors for suicide among Aboriginal youth are being male, a history of substance abuse (especially solvents or inhalants), a history of a mental health problem, a paternal history of substance abuse or mental disorder, feelings of alienation from the community, and a history of physical abuse (Kirmayer, et al., 2000).

In a recent follow-up of a school-based epidemiological study of U.S. Northern Plains adolescents (Beals, et al., 1997), who had been studied as young children, fully 43% received a diagnosis of at least one mental disorder. The most frequent diagnoses were disruptive behaviour disorders including ADHD and conduct disorders (22%); substance abuse disorders (18.4%); anxiety disorders (17.4%); affective disorders (9.3%); and post traumatic stress disorder (5%). Rates of co-morbidity were very high, with almost one-half of those with mental disorders also diagnosed with a substance abuse disorder. Compared to adolescents in the general population, these American Indian adolescents suffered much higher rates of ADHD, conduct disorder, anxiety disorders, and substance abuse disorders; rates of depressive disorders were equivalent.

The few available studies from the U.S. indicate that very few American Indian children and youth who suffer from mental disorders receive appropriate care for that disorder, and most that do receive treatment services through the juvenile justice system (Costello, et al., 1997). The prevalence of mental illness among Aboriginal youth in the juvenile justice system is very high; 49% of Indian youth detained in a juvenile detention facility on a U.S. Northern Plains reserve were diagnosed with at least one mental disorder in a recent study (Duclos, et al., 1998).

Prevalence of mental illness among Aboriginal adults. A few epidemiological studies have documented that Canadian Aboriginal peoples suffer from a range of mental health problems at higher rates than occur in the general population (Kirmayer, 1994; Royal Commission on Aboriginal Peoples, 1995; Roy, et al., 1970; Sampath, 1974; Waldram, et al., 1995). Rates of mental disorders in Aboriginal communities vary greatly, however, from levels comparable to those found in the general population up to twice those of neighboring non-Aboriginal communities (Kirmayer et al., 2000).

In adults, alcoholism and alcohol-related problems are of the greatest concern. In 1996-97, 46% of people in detoxification and treatment facilities in the Regina Health District were of First Nations or Métis descent (Health Canada, First Nations and Inuit Health Branch, November, 1999). May (1996) has analyzed data from the Indian Health Service in the U.S. that show alcohol-specific deaths (deaths directly attributable to alcohol such as those from cirrhosis and alcohol dependence syndrome) among American Indians are 3-13 times higher than U.S. averages from Indian males and 4-31 times higher for Indian females. There is tremendous variation in these rates across tribes and within tribes; there is, however, no Indian Health Service area where alcohol-specific mortality is lower that the 1995 U.S. average of 6.7/100,000 death rates from these causes, with rates for American Indians varying from 21.7/100,000 in the Oklahoma City, OK area to 108.7 in the Aberdeen, SD area (Indian Health Service, 1999). In addition, alcohol is thought to be involved in the majority of deaths due to accidents, homicides and suicides among Aboriginal people (May, 1996).

In a general review of the National Native Alcohol and Drug Abuse Program (1998) in Canada, almost 90% of Aboriginal leaders and health and social service providers surveyed reported that the use of alcohol in their communities was either a constant problem (40-51%) or a frequent problem (38-43%).

Estimates of mental disorders among American Indians with substance abuse problems range from 35-60% (Young, et al., 2001). Mental disorders that are found in association with substance abuse as a comorbid condition are major depressive disorder, bipolar disorders, dysthymia, anxiety disorders, post traumatic stress disorder, and schizophrenia (Young et al., 2001).

The alarming increase in reported cases of HIV/AIDS in Canada's Aboriginal population in recent years has resulted in the prevalence of AIDS being almost eleven times higher than the national average (Health Canada, First Nations and Inuit Health Branch, November, 1999). Aboriginal cases of AIDS are more common in younger Aboriginals, and are often attributed to injecting drug use (Health Canada, 2001).

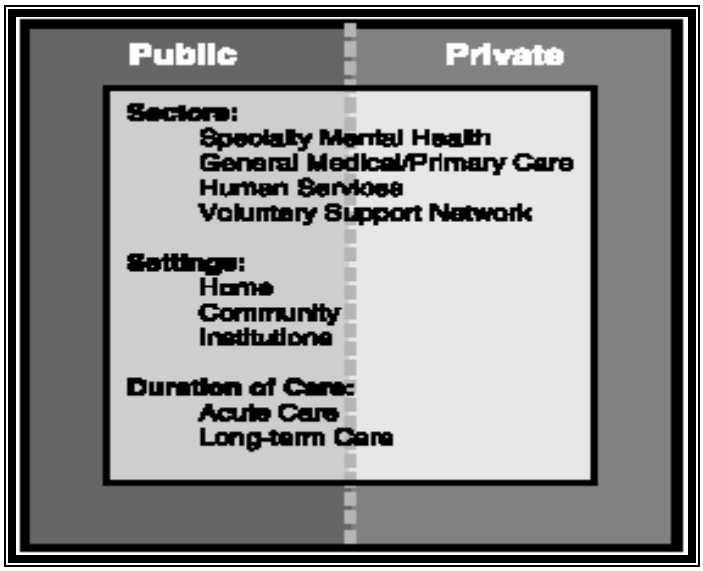
Substance abuse is also involved in much of the domestic violence among Aboriginal peoples, another great concern. The National Clearinghouse on Family Violence (1997) reports the following: a 1989 study by the Ontario Native Women's Association found that 8 out 10 Aboriginal women in Ontario had personally experienced family violence, of these women, 87% had been injured physically and 57% had been sexually abused; in some northern Aboriginal communities, it is believed that between 75% and 90% of women are battered, and 40% of children in these communities had been physically abused by a family member; and the abuse of older adults has been identified as a serious problem in some First Nations communities.

Chapter Two

An Overview of the Mental Health System

Mental health service in Saskatchewan and across Canada is a complex and fragmented patchwork, so much so that it is best referred to as the *de facto* mental health system (see Regier et al., 1993b). The de facto system may be characterized as having four distinct sectors, as occurring in several settings and varying in duration of care, and financed by both public and private dollars (see Figure 1).

Figure 1. The Mental Health Service System (U.S. Surgeon General, 1999)



Mental Health Sectors

The four sectors of the system are the specialty mental health sector, the general medical/primary care sector, the human services sector, and the voluntary support network sector.

Specialty mental health services include services provided by specialized mental health professionals (e.g., psychologists, registered psychiatric nurses, psychiatrists) and paraprofessionals (e.g., mental health therapists), that are provided in health district/authority mental health facilities and agencies, CBOs, and in private offices.

The administration and delivery of mental health services and programs was transferred to health districts/authorities in 1995. Saskatchewan Health, Community Care Branch retains a role in funding, consultation and policy guidance. The Saskatchewan statistics reported here are taken

from the Saskatchewan Mental Health Program Review (Saskatchewan Health, Community Care Branch, 2001).

Mental health services are available in over 100 locations thorough out the province; services are provided each year to over 20,000 people as outpatients, and there are over 5,000 admissions to the eight inpatient mental health facilities annually. The total budget for mental health in the Department of Health was $77.8 million in 2000-01; of this, $57.4 million went to District Health Services for expenditures in mental health services. Fifty-seven percent went to inpatient services and 43% to outpatients. The $57.4 million for mental health services in Districts represents 3.8% of total spending by Districts for all health services ($1.48 billion) in 2000-01; in addition, Districts spent $12.4 million (0.8%) for alcohol and drug services, and $326.5 million (24.2%) for long term care services—both of which are services in which a significant proportion of patients are suffering from mental disorders.

Department of Health expenditures for mental health have increased about 16 % in the past five years, while total Health expenditures have risen by about 40% over this time to $2.08 billion in 2000-01 ($2.34 billion in the 2002-03 budget). Thus, while the size of the mental health budget has increased, its share of the health budget has decreased. If the budget for mental health had increased at the rate of the total health budget over the past five years (i.e., 40%), mental health would have received $91.4 million in 2000-01, $13.6 million more than it did receive.

While, in general, mental health services should be evaluated and decisions made about public spending on the same basis as for other health services, there are certain significant features that distinguish at least some of the possible interventions (WHO, 2001). One is that there can be large benefits to controlling some mental disorders. In contrast to the benefits that arise from control of communicable diseases, where treating one case may prevent others and immunization of most of the susceptible population also protects the non-immunized, the benefits arising from mental health care often appear in non-health forms, such as reduced accidents and injuries in the case of alcohol use or lower cost of some social services. These cannot be captured in a cost-effectiveness analysis but require some judgment of the overall social benefit from both health and non-health gains.

Difficult as it may be to work out priorities from the variety of relevant criteria, any rational consideration of the issues just mentioned offers the opportunity to improve on arbitrary or merely historical allocation of resources. This is especially true if mental health care is to get more public resources. Expansion in equal proportions of whatever is currently financed is unlikely to be either efficient or equitable. A needs-based allocation is a more equitable means for distributing resources.

Mental health services in districts/authorities are delivered in four program areas: child and youth services; adult community services; psychiatric rehabilitation services; and mental health inpatient services. In addition, psychiatrists provide private services on a fee-for-service basis paid for through the Medical Services Plan.

Child and youth services. The full range of services is not available in many districts/authorities. In particular, the lack of adequate services to children with severe and persistent mental disorders is a chronic issue, a part of which is a severe shortage of child psychiatrists and psychologists. The size of case loads ranges from 20 to 60. The wait times for child and youth mental health services are significantly longer than for adult services, more than four months in at least three districts/authorities. There are only 6 hospital beds available for

adolescents in Saskatoon and 11 beds in Regina; a number of youth are hospitalized in pediatrics units and in locked adult mental health units.

Adult community services. A range of assessment and therapy services is available in most districts/authorities, and crisis services are provided by CBOs in three locations. The size of case loads ranges from 20 to 70. More than half of the service areas are above the minimum standard (cited by Health) for number of mental health outpatient staff (3.5 FTEs per 10,000 population); staffing is below this standard in Regina, Northeast, Prince Albert, and Midwest areas. In a number of smaller districts/authorities community based services are very limited resulting in extended hospital stays.

About one-half of the calls and referrals for mental health outpatient services in the province are denied in favour of devoting scarce resources to those most seriously mentally disordered.

Psychiatric rehabilitation services. Community based services for persons with long-term mental disabilities include case management, family support, vocational and recreational programs, and supported housing in approved or group homes and apartment living options. Much of these services are provided through about 10 CMHA Branches and 16 CBOs (e.g., Phoenix Residential Society, Saskatoon Housing Coalition, Schizophrenia Society of Saskatchewan).

Mental health inpatient services. The Saskatchewan Hospital at North Battleford provides rehabilitation services for about 178 long-term, severely disabled patients, as well as inpatient forensic assessment services (25 beds); another 40-45 beds for psychiatric rehabilitation are located in other hospitals. There are about 243 mental health acute inpatient beds distributed across eight inpatient facilities in the province (Battlefords, Weyburn, Moose Jaw, Yorkton, Prince Albert, Regina, Swift Current, and Royal University and City Hospitals in Saskatoon). In addition, over 12,000 mental health inpatient days in 1999-00 were in general hospital units, about 14% of all inpatient days for mental health reasons.

The size of case loads ranges from 20 to 75, in over half of the districts/authorities the average caseloads exceed the recommended 40-45 cases. The total number of inpatient days for mental health reason has decreased by about 16% in the past three years, due in part to bed closures. In other part, the average length of stay has decreased from 21 days in 1995-96 to about 15 days in 2000-01, slightly below the Canadian average. A preliminary study by HSURC (2000) found that patients in the three districts studied were remaining in acute care for too long a time, on average, after the acute phase of their illness was over. One-half of the admissions to inpatient units in 1999-2000 were readmissions; 29% of readmitted patients had been out of hospital less than 30 days before being readmitted.

Recruitment and retention of nurses is a significant issue that has forced the closure of beds in most inpatient units. There have been chronic shortages of psychiatrists, psychologists, social workers, and RPNs and/or RNs employed in psychiatric units in all regions.

The general medical/primary care sector consists of health care professionals (e.g., family physicians, registered nurses and nurse practitioners, licensed practical nurses, and other medical specialists) and the settings (i.e., offices, clinics, and hospitals) in which they work. These settings are designed for the full range of health care services, including, but not specialized for, the delivery of mental health services.

The integration of mental health care into general health services, particularly at the primary health care level, has many advantages (WHO, 2001). These include: less stigmatization of patients and staff, as mental and behavioural disorders are being seen and managed alongside physical health problems; improved screening and treatment, in particular improved detection rates for patients presenting with vague somatic complaints which are related to mental and behavioural disorders; the potential for improved treatment of the physical problems of those suffering from mental illness, and vice versa; and better treatment of mental aspects associated with "physical" problems. For the health administrator, advantages include a shared infrastructure leading to cost-efficiency savings, the potential to provide universal coverage of mental health care, and the integration and better use of community resources which can partly offset the limited availability of mental health personnel.

In 1999-00, 109, 516 discrete individuals received over 500,000 mental health services from their family physician (Saskatchewan Health, Community Care Branch, 2001). In Alberta, the top billing category by physicians through the Alberta Health Care Insurance Plan is for mental health reasons (CMHA, 2001).

About one-third of family practice patients in Canada have identifiable mental health problems, and 25% of all patients who visit their family physician will have a diagnosable mental disorder (National Conjoint Committee on Mental Health Care, College of Family Physicians of Canada and the Canadian Psychiatric Association, 1996; Kates et al., 1997). These figures are likely higher for teenagers and the elderly.

Of the physician services for mental health reason in the province, the large majority of which are outpatient services, family physicians provide 68%; psychiatrists provide 32%. As is documented in Chapter 4, patients diagnosed with mood disorders and anxiety disorders constitute more than one-half of the mental health outpatients seen by physicians. Other diagnostic groupings represented among outpatients seen by physicians in the province include schizophrenia (4.8%), dementias (2.2%), alcohol and drug disorders (7.9%), adjustment and stress disorders (5.1%), and infancy, childhood and adolescent disorders (7.3%).

In a recent submission to the Commission on the Future of Health Care in Canada, the Saskatchewan Psychological Association (2001) documented the prevalence of mental illness at the primary care level and the costs of inadequate mental health services typically provided by family physicians and nurses. Among the key findings, most from U.S. research, are:

- 60% of physician visits are by patients with no demonstrable physical disease;
- individuals with anxiety disorders use medical resources at 40% higher rates, tending to seek medical services rather than those in mental health;
- medical costs are 46% higher for patients with untreated stress, 70% higher with untreated depression;
- mental health problems are often overlooked or misdiagnosed in primary care (Hirschfeld et al., 1997); e.g., primary care physicians diagnosed depression with a sensitivity of only 39% even after specialized education and new practice guidelines (Thompson et al., 2000).

There is considerable research showing that brief psychological interventions for a range of health problems in primary care settings are not only effective but reduce subsequent health care utilization costs by an average of 20-30 percent (as documented in a comprehensive meta-analysis of 91 studies by Chiles et al., 1999; CPA, 2001). Brief psychological interventions for depression and anxiety disorders have been shown to be more effective and less costly than

pharmacological treatments. Access to of such psychological treatment in primary care settings in Saskatchewan is, for all practical purposes, nil. The need for and benefits of psychological treatment for anxiety and mood disorders in primary health care settings are discussed in Chapter 3.

A good example of comprehensive mental health services provided in primary care is the Buckingham project in rural England (Falloon & Fadden, 1993). Falloon's multidisciplinary team included 18 family physicians, 24 community and mental health nurses, a clinical psychologist, a social worker, a occupational therapist, 2 psychiatrists, and 3 administrative staff serving a population of 35,000. The services emphasized community management and integration among health care providers, use of evidence-based therapies delivered by mental health nurses trained and supervised by psychologists, early detection, crisis intervention and home-based acute care, integrated clinical management of long-term disabled in the community. Cost-benefit analyses have been quite positive.

More modest than such a comprehensive mental health service at the primary care level are programs to provide brief structured treatment for depression and anxiety delivered by mental health specialists (psychologists, RPNs, social workers) employed in primary care practices, as is the case at the Saskatoon Community Clinic for instance. Research has shown that such treatments, evidence-based ones, are cost-effective in primary care settings (Eisenberg, 1992; Katon et al., 1996; Mynors-Wallis et al., 1995; Public Health Service Agency for Health Care Policy and Research, 1993).

The human services sector consists of social services, housing, employment and disability programs, services in corrections and justice and education, and many services delivered by community based organizations, often funded by Government, such as vocational and other rehabilitation services. Social workers, teachers, corrections workers and other human service workers are found in the human service sector.

Many mental disorders require psychosocial solutions. Thus links need to be established between mental health services and various community agencies at the local level so that appropriate housing, income support, disability benefits, employment, and other social service supports are mobilized on behalf of patients and in order that prevention and rehabilitation strategies can be more effectively implemented.

In Saskatchewan, services available to persons with mental health disorders and problems and funded by Departments of the Saskatchewan Government, include the following.

Department of Social Services

- Financial assistance through the Saskatchewan Assistance Plan, Employment Supplement, Child Benefit, Income Plan, Child Day Care Subsidy, and Family Benefits
- Career and Employment Services
- Child and Family Services--Child Protection Services, Community Crisis Centres
- Child Nutrition and Development Program
- Transition Houses, Sexual Assault Services and Outreach Services
- Therapeutic foster care
- Teen and young parent program
- Community Living--programs and services for about 3600 intellectually disabled delivered primarily through community-based social, residential (including Valley View), vocational and early childhood agencies

- Children's facilities for assessment and stabilization (2)
- Social Housing Services
- Rent Supplement Program
- Saskatchewan Assisted Living Services (SALS)
- Shelter Enhancement - New Projects—emergency housing for women, children and youth who are victims of family violence
- Social Housing Rental Program

Department of Learning

Education

- Kids First—Early Childhood Intervention Program
- Community schools
- Indian and Métis Education Development programs
- Integrated school-linked services
- Special education programs

Post-secondary Education & Skills Training

- Employability Assistance for People with Disabilities
- Job Start/Future Skills—work based training for unemployed
- Provincial training allowance
- Student counseling and health services at the two universities, SIAST, and Regional Colleges

Department of Justice/Corrections and Public Safety

- Aboriginal family violence prevention
- Alternative measures
- Community-based crime prevention programs
- Family Law Support Services
- Mediation services
- Victims Services
- Correctional centres (6), camps (3), community training residences (6), probation services (16 offices)
- Young offender secure (7) and open (4) custody facilities

Voluntary sector and informal care and support

The voluntary sector in mental health includes consumer self-help and advocacy, consumer operated programs, family self-help and advocacy, and other voluntary community programs. While it may go without saying that much of the care and support given to those struggling with mental health disorders comes from family caregivers, friends and community, what does need to said is just how critical informal care giving is.

Consumers of mental health services have consistently told us that what contributes to their recovery as much as formal services are social relationships, often with other consumers or family (CMHA, 2001a).

Consumer self-help groups combat stigma, and they can lessen feelings of isolation, increase practical knowledge, and sustain coping efforts (Kurtz, 1997; Galanter, 1988; Liberman et al., 1991). Consumers have successfully operated drop-in centres (e.g., CMHA, Crocus Co-op) case management programs, businesses (e.g., Phoenix), and crisis services (Van Tosh & del Vecchio, 1999). Consumers can and should be equal partners in mental health planning, such as in the Mental Health Advisory Committees to Health and the Saskatoon District Health Board, and serve as advocates in their communities.

Family caregivers need support--families caring for adults with serious mental illness and intellectual disability, and for older adults with mental and physical disabilities. Virtually all studies find elevated symptoms of depression and anxiety among caregivers of the mentally ill. Self-help and support groups for family members enhance the quality of life for caregivers and benefit the mentally ill family member. For caregivers of older disabled adults, support groups and other services can delay the institutionalization. In communities, the voluntary sector provides adult day care and other respite services to aid caregivers striving to care for family members at home.

Parents and families caring for children with serious mental illness need to be full partners in the care of their child. Family participation improves the process of delivering mental health services to children and their outcomes (Koren et al., 1997; Thompson et al., 1997). Family support services provided by the voluntary sector can include self-help groups, respite care, and family associate programs where paraprofessionals provide practical assistance to families. The large majority of parents caring for children with mental disorders have said that emotional support is the most helpful aspect of family support services (Friesen, 1990).

Voluntary and informal care and support for the mentally ill often requires leadership and assistance from government, community leaders, and from professionals. Though there are exceptions, voluntary and informal supports are not initiated or sustained in the absence of such leadership and assistance. 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.

The voluntary sector can act as “bridge builders”, facilitators, advocates and catalysts for change to advance the interests of people dealing with mental disorders and problems. In Saskatchewan, the CMHA-Saskatchewan Division, unfortunately, has not had the resources to engage in much such advocacy and public education work, due in part to the significant rehabilitation services it provides for the seriously mentally ill.

Mental Health Settings

The settings for care and treatment include **institutional**, community-based, and home-based. The former refers to facilities such as the Saskatchewan Hospital North Battleford and some long term care facilities, which usually are seen by patients and families as large, regimented, and impersonal. These are removed from the community by distance and frequency of contact with friends and family.

The change from institutional care of mentally ill persons to care in the community accompanied by the availability of beds in general hospitals, pioneered in Saskatchewan in the 1960s, is certainly the most significant positive change within the mental health system in modern history. For a sound de-institutionalization process the establishment and maintenance of community support systems is critical, including an adequate human resource base of mental health professionals such as Registered Psychiatric Nurses, Psychologists, Social Workers, and Psychiatrists.

Community-based services are close to where patients or clients live. Community-based services include the eight mental health units in hospitals throughout the province, approved homes and other small residential settings run by CBOs, and the mental health services provided by health districts/authorities, CBOs, social services, and in schools.

The characteristics of providing care in the community, according to the WHO (2001), are:

- services which are close to home, including general hospital care for acute admissions, and long-term residential facilities in the community;
- interventions related to disabilities as well as symptoms;
- treatment and care specific to the diagnosis and needs of each individual;
- a wide range of services which address the needs of people with mental and behavioural disorders;
- services which are coordinated between mental health professionals and community agencies;
- ambulatory rather than static services, including those which can offer home treatment;
- partnership with care givers and meeting their needs;
- legislation to support the above aspects of care.

Home-based services include formal home care services and informal supports provided in an individual's residence. Home care services that can provide adequate attention to and care for older adults suffering from Alzheimer's disease or depression are generally not available in the province.

Duration of Care

The duration of care is divided between services for the treatment of **acute** conditions and those devoted to the **long-term care** of chronic (i.e., severe and persistent) conditions, such as schizophrenia, bipolar disorder, and Alzheimer's disease. The former, provided in psychiatric units in general hospitals, and in beds "scattered" in general hospital wards, includes brief treatment-oriented services, primarily pharmacotherapy. Long-term care includes residential care as well as some treatment services. Residential care may be seen as "custodial," when supervised living predominates over active treatment, as is often the case in approved homes for the mentally ill in the province.

Financing Mental Health Care

Financing of the de facto mental health system refers to the payer of services. The system is largely financed by the **public** (i.e., government) sector, including provincial departments of Health, Social Services, Learning, Corrections, and the Federal Government for services to First Nations peoples and in the area of federal corrections. Public sector financing includes both services directly operated by health districts/authorities and other government funded agencies

such as CBOs, and also to physician fee-for-services financed through the Medical Services Branch of Health. Publicly financed services may be provided by private organizations.

The term "**private sector**" refers both to mental health services directly operated and funded by private agencies (e.g., Ranch Erlo Society), and to services financed with private resources (e.g., employer-provided private insurance for EAPs, client out-of-pocket).

Twenty years ago very few psychologists or social workers provided private health care services. Today, the majority of psychologists in Canada work in the private sector on a part-time or full-time basis (CPA, 2001b). The growth in coverage for psychological and other mental health services by employee assistance programs and private insurers speaks to the cost-effective benefits and the demand.

In 1998, it is estimated that of the 3 million visits to psychologists and social workers by Canadians suffering from depression and distress a full 73% took place on a fee-for-service basis outside of institutions and publicly funded health care settings (Stephens & Joubert, 2001). Total costs for these visits exceeded $278 million.

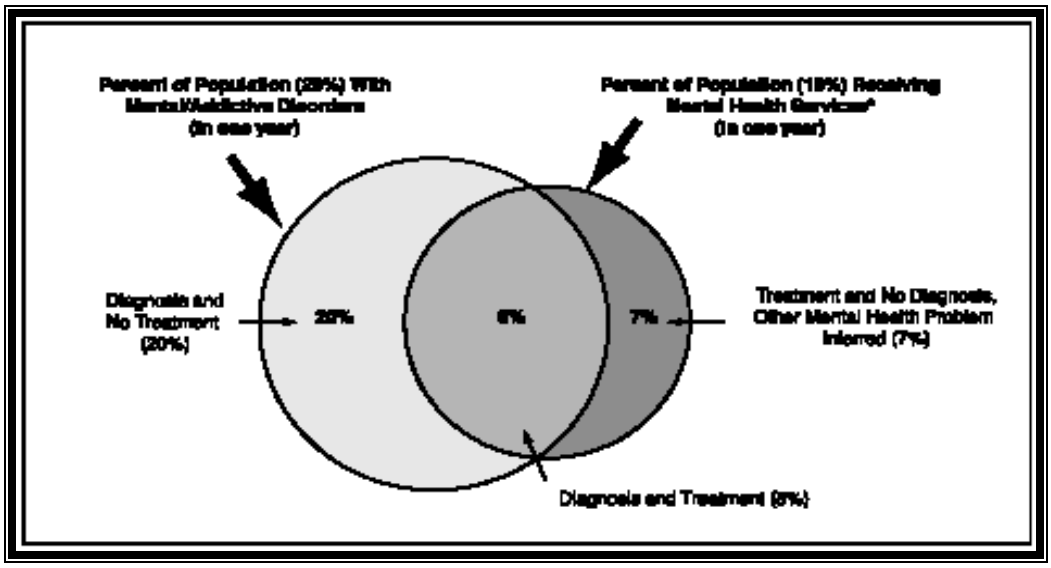
The cost of private mental health services in Saskatchewan, provided by psychologists, social workers and other non-regulated counselors, is estimated at $12 million as documented by a survey completed for this report (Chapter 4).

Patterns of Use of Mental Health Services

Adults. In the U.S., according to recent national surveys (Regier et al, 1993b; Kessler et al., 1996), a total of about 15 percent of the U.S. adult population use mental health services in any given year. Eleven percent receive their services from either the general medical care sector or the specialty mental health sector, in roughly equal proportions. In addition, about 5 percent receive care from the human services sector, and about 3 percent receive care from the voluntary support network. (The overlap across these latter two sectors accounts for these figures totaling more than 15 percent.)

Slightly more than half of the 15 percent of the adult population that use mental health services have a diagnosable mental or addictive disorder (8 percent), while the remaining portion has a mental health problem (7 percent). Bearing in mind that 28 percent of the population have a diagnosable mental or substance abuse disorder, only about one-third with a diagnosable mental disorder receives treatment in 1 year. The majority of those with a diagnosable mental disorder are not receiving treatment, as illustrated below.

Figure 2. Annual prevalence of mental/addictive disorders and services for adults (US Surgeon General, 1999)

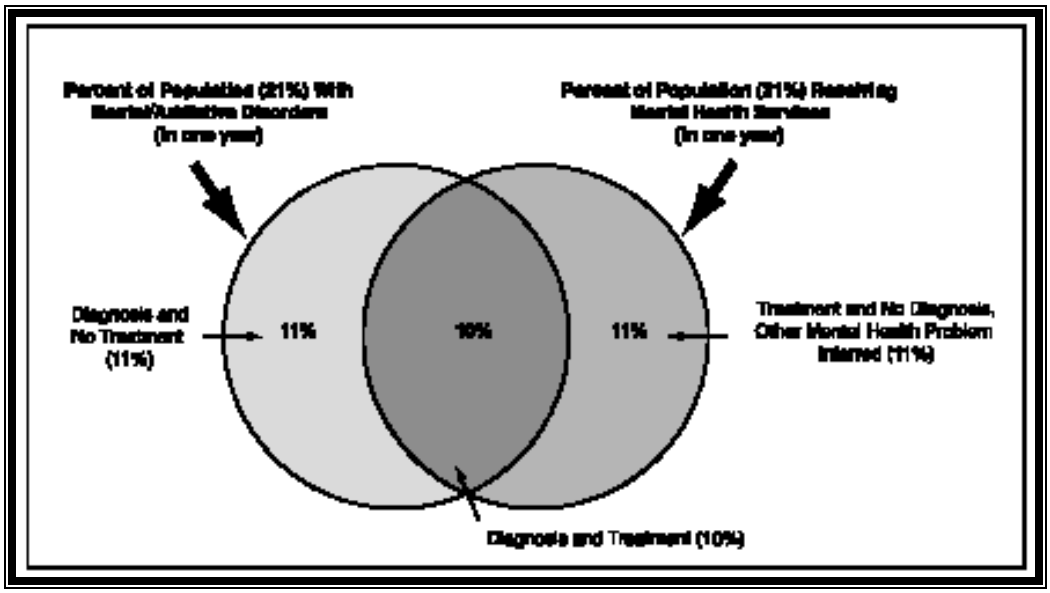


These utilization figures are from U.S. studies. The proportion of the adult population that utilize mental health services in Saskatchewan and Canada is very likely significantly less, according to estimates of researchers here.

Children and youth. Similarly, about 21 percent of the child and adolescent population use mental health services annually. Nine percent receive care from the health care sector, almost exclusively from the specialty mental health sector. Seventeen percent of the child and adolescent population receives care from the human services sector, mostly in the school system, yet there is much overlap with the health sector (again accounting for the sum being more than 21 percent). The distribution of those who do and do not currently meet diagnostic criteria for a mental disorder is similar to that for adults (Figure 3).

These utilization figures are, again, from U.S. studies. The proportion of the population that utilize mental health services in Saskatchewan and Canada is very likely significantly less, according to estimates of researchers here. Estimates in Saskatoon suggest that less than 4% of the population of children and youth access mental health services (Dr. T. Greenough, personal communication, May 2002)

Figure 3. Annual prevalence of mental/addictive disorders and services for children (US Surgeon General, 1999)



Prevention of mental illness and promotion of mental health

Left out of the above overview of the mental health service system is the prevention of mental illness and the promotion of mental health, arguably the most critical components of the mental health system in the long term, and certainly the most neglected components.

In Saskatchewan, a small portion of the resources for mental health in each district/authority is devoted to mental health promotion and education. Recent examples include: *Building Healthy Young Minds Handbook* , developed by the Regina Health District, for use in elementary schools across the province; *Schizophrenia: The Great Disabler of Young People*, a video produced and distributed by the Schizophrenia Society of Saskatchewan; the *Problem Gambling Community Program*, providing workshops and in-services offered by the CMHA (Saskatchewan Division).

It is clear that offering only more "services" will not respond effectively to the population's mental health needs. Since approximately 60% of people with mental health problems do not receive care from a health professional, the apparent gap in services is simply too big to fill. What is evidently needed is a different kind of investment to promote the population's mental health. Generally speaking, this could take the form of developing individual and community resourcefulness, and promoting resilience among individuals of all ages (e.g., Pransky, 1991; Durlak & Wells, 1997) The significant contribution of mental health problems to the global burden of disease is being addressed by a growing number of countries, including Canada, the United States, Australia, New Zealand, and the Member States of the European Union, all of which are developing national plans of action or other initiatives to promote the mental health of their populations (Joubert, 2001). The dollars thus invested would represent a small figure compared with the global burden of mental illness if nothing is done.

Mental Health Services for First Nations and Métis Peoples

Mental Health services for First Nations and Métis peoples are considered separately for reasons noted in Chapter 1.

The public and private mental health services reviewed in this Chapter are available to First Nations and Métis peoples. In fact, Aboriginal peoples suffering from mental health disorders and problems are overrepresented in many of the conventional services provided in the province, especially in child and youth mental health services, alcohol treatment services, and some mental health services funded by the Departments of Social Services (e.g., foster care, children's facilities, child protection, community crisis centres, social housing, shelter enhancement), Learning (e.g., Kids First, community schools), and Corrections and Public Safety (young offender services, correctional centres, camps, community training residences, and probation services), very significantly overrepresented in services provided in Social Services and Corrections by all reports.

Health services for First Nations and Inuit are the responsibility of provincial, territorial and federal governments. The provinces/ territories provide and/ or pay for insured physician and hospital services. The federal government provides treatment and public health services in remote areas and public health services in non-isolated First Nation communities through the First Nations and Inuit Branch (FNIB, formerly the Medical Services Branch) of Health Canada. Services include community preventive health and health promotion programs and services and environmental health surveillance. Emergency diagnostic and treatment services are provided by the FNIB when not available otherwise (see the web site of the First Nations and Inuit Branch, Health Canada, for documentation of this and other information presented in this section).

The Federal Government has over the years maintained the position that it is responsible for health services of Treaty or Status Indians on living on reserves; non-status First Nations, First Nations living off-reserve, and Métis peoples--who account for well over half of the Aboriginal peoples in the province--are not normally provided health services by the federal government.

First Nations and Inuit people have worked to gain more self-determination over all areas of their lives for a long time. As a result, community-based health programs are gradually being transferred by Health Canada to First Nations and Inuit control, either in comprehensive transfer agreements or more limited agreements, for all or most of the community health services while setting up their own management structures to directly administer the transferred programs and services. As of December 2001, 23 of Saskatchewan's 83 First Nations had signed transfer agreements. Funding is provided by contribution and contract arrangements.

Mental health services provided by Health Canada, FNIB, are very limited and generally restricted to the following programs:

- A small amount of the funding to some First Nations under Transfer agreements for community-based health programs covers mental health/social service professionals and paraprofessionals, as determined by the First Nation. There are concerns about what paraprofessionals can be expected to accomplish in dealing with serious mental health problems and addictions with limited training and/or ongoing support.

- Crisis intervention services in mental health which are covered under the non-insured health benefits program and includes fees for non-insured mental health professional services, transportation costs, and most significantly, in terms of costs, non-insured

psychotropic drugs (central nervous system drugs—antidepressants, sedatives/tranquilizers, and analgesics (Tylenol #3)-- accounted for 34% of all prescription drug costs in 2000-01 across the country; in Saskatchewan these prescription drug costs amounted to $24 million.

- Early Childhood Development, Aboriginal Head Start programs (which are presently serving about 12% of children age 0-6 years on reserve, and 7.6% of 3-5 year old children living off reserve).

- Early Childhood Development programs focused on FAS/FAE prevention and intervention. In September 2000, Canada's First Ministers established Early Childhood Development as a new national social priority; the province is receiving about $73 million over five years for the Kids First program (Department of Learning) which is targeted at families at high risk for FAS/FAE and other disorders in children, the majority of which are Aboriginal.

- Native National Alcohol and Drug Abuse Program; ten programs have been funded in Saskatchewan over the past 15 years.

- Telehealth demonstration projects, one of which provided mental health services to a remote Northern Cree community in Saskatchewan offered by clinical psychologists at the U of S in 2000-01 that proved to be reasonably successful.

The federal government has also provided five-year funding to the Aboriginal Healing Foundation for projects that support Aboriginal people in building and reinforcing sustainable healing processes that address the legacy of physical abuse and sexual abuse in the Residential School system, including intergenerational impacts. In Saskatchewan, 121 projects, totaling about $28m have been funded to date; projects cover a broad range of healing initiatives being provided by individual First Nations, Tribal Councils, Friendship Centres, Indian Child and Family Service units, schools, Métis organizations, and the SIFC School of Social Work for their Master's program in Indian Social Work (see the web site of the Aboriginal Healing Foundation for documentation).

Despite what may appear to be a good deal of mental health service, funding and programs for Aboriginal peoples is very limited and fragmented. The gaps between federal and provincial service has been identified repeatedly over many years. Many Aboriginal people can not access mental health services even when it is available provincially. Coordination of services between federal and provincial governments is a long-standing issue.

Recent studies have shown that First Nations under-utilize the health system by as much as 30% when total health care expenditure per capita are compared to non-Aboriginals (Jock, 1999).

The most critical need is for a comprehensive mental health program for Aboriginal peoples so as to enhance treatment, access and control, as identified by the Assembly of First Nations' Health Director, Allen Deleary (AFN/MSB Joint Health Policy Forum, 1999).

Saskatchewan Health, Community Care Branch, has facilitated a couple of integrated mental health programs in recent years: the Circle of Strength program for children, and services for adults and families in collaboration with the Yorkton Tribal Council. Such integrated programs offer many advantages compared to visits to a private mental health specialist off-reserve, the typical service provided under the non-insured health benefits program of Health Canada, FNIB.

Chapter Three

An Overview of Evidence-Based Mental Health Treatment Programs

A general overview of evidence-based treatment programs for children and youth, adults, and older adults is offered. The focus is on treatment for the most prevalent and the most debilitating mental disorders and problems. This overview borrows heavily from *Mental Health: A Report of the U.S. Surgeon General* (1999), a report that provides the most comprehensive and generally accessible review available today.

The U.S. Surgeon General offers two important conclusions about treatment for mental disorders and problems:

> ***The efficacy of mental health treatments is well documented, and***
>
> ***A range of effective treatments exists for many mental disorders***

Children and Youth

Two broad categories of mental disorders in childhood and adolescence are commonly considered by professionals.

Disorders of psychological development are characterized by impairment or delay in the development of specific functions such as speech and language (dyslexias) or overall pervasive development (e.g., autism, and severe mental retardation).

The second category includes, **behavioural and emotional disorders**, includes attention deficit/hyperactivity disorder, disruptive disorders, and emotional disorders such as anxiety and depression.

Pervasive developmental impairments (autism, severe mental retardation)

Autism, found in 10-12 children per 10,000 (Bryson & Smith, 1998), is a severe, chronic developmental disorder which results in significant lifelong disability. Social and language development is impaired. Thirty years of research has now demonstrated the efficacy of applied behavioural methods in reducing inappropriate behaviour and in increasing communication, and appropriate social behaviour (Lovaas, 1987; McEachin et al, 1993; Rogers, 1998). Treatment requires skilled therapists, and both intensive and extensive time in treatment.

Two community-based organizations in the province offer reasonably comprehensive treatment and education services for autistic children: the Autism Resource Centre, Regina; Autism Treatment Services of Saskatchewan in Saskatoon. Both services are understaffed and have long waiting lists.

There is some evidence that home-based teaching for preschool autistic children can effect at least short-term improvements in communication (Ozonoff & Cathcart, 1998).

There is also some evidence that certain antipsychotic and anti-depressant drugs can be beneficial for older autistic children, though undesirable side effects often develop.

Severely mentally retarded children and youth benefit from applied behavioural treatment programs. As with such treatment for autistic children, effective treatment programs are resource intensive and require skilled therapists.

Care providers who are well trained and skilled in applied behavioural treatment methods, the most clearly effective treatment in working with autistic and mentally retarded children, are not available in Saskatchewan. Post-secondary training programs at the two universities and at SIAST do not offer adequate training opportunities in applied behavioural treatment.

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) is a cluster of symptoms of cognitive and behavioural impairment caused by maternal consumption of alcohol during pregnancy and resulting in central nervous system damage. It is difficult to diagnose, requiring expert pediatric and psychological assessments. The rate of incidence of FAS in Saskatchewan has been estimated at 0.585 per 1,000 live births (Habbick et al., 1996). This is a conservative estimate; using more liberal diagnostic criteria that include a broader spectrum of symptoms (referred to as Fetal Alcohol Effects – FAE)), estimates have ranged as high as 100/1000 live births on a First Nations reserve in Manitoba (Square, 1997). Clinicians today frequently consider FAS/FAE as a spectrum of "alcohol related neurodevelopmental disorders" with symptoms ranging from severe to mild, with prevalence rates about ten times greater than rates of FAS diagnosis.

It is clear that the incidence of FAS is considerably higher in many First Nations communities where the prevalence of alcohol abuse is very high.

The burden and costs of a life lived with FAS/FAE are enormous. In more severe cases and without early and prolonged treatment, the effects include comorbid conduct disorder, school failure, antisocial behaviour and criminal activity, co-occurring adult mental disorders and substance abuse, unemployment, and poor social and family relations. Estimates of the long-term costs of services for FAS youth (including health, special education, social, and corrections services) are over $1million per child.

Early detection and intervention, followed by behavioural treatment with parents, teachers and in the community, similar to a multisystemic therapy approach, is thought to be the treatment of choice by clinicians. Such treatment is very resource intensive, and must be maintained over considerable time.

There is very limited capacity to diagnose FAS in the province (done primarily at the Kinsmen Centre in Saskatoon and the Wascana Hospital in Regina). Waiting lists for diagnosis are very long. There is very limited capacity for early intervention and treatment, and even less capacity

for primary prevention. The early childhood intervention program in the province, Kids First, which has a significant focus on prevention, and early intervention with children at high risk for FAS, is beginning to be implemented across the province. The main approach is home-visits to high-risk mothers during pregnancy and for some time following the birth of a child. This is an important, much needed, initiative, funded by about $73 million in federal transfer dollars over five years. Another similar prevention and early intervention program, "Roots and Wings", operated in Saskatoon for the past two years, funded by Health Canada.

Attention Deficit/Hyperactivity Disorder (ADHD)

ADHD, the most commonly diagnosed behavioural disorder of childhood, occurs in 3-5% of school-age children in a 6-month period (Shaffer et al., 1996; Wolraich et al., 1996). In practice, the diagnosis is often made in children who do not meet the recommended criteria in DSM-IV. Boys are four times more likely to have the disorder than girls.

The cornerstones of treatment are support and education of parents, appropriate school placement, and psychostimulants.

The treatment of ADHD children with psychostimulant medication has been found to consistently reduce core symptoms in hundreds of randomized controlled trials. Their use is the most efficacious and safest of any drug treatment for children. Their long-term efficacy and long-term safety is less well established. Common side effects include insomnia, decreased appetite, stomach aches, headaches, and jitteriness.

There are concerns that children, particularly active boys, are overdiagnosed with ADHD and that psychostimulants are overprescribed. Most researchers, however, believe that much of the significant increase in stimulant prescriptions in recent years is in fact due to better diagnosis and more effective treatment of a prevalent disorder. Family physicians are more likely than either pediatricians or psychiatrists to prescribe stimulants and less likely to do so before expert diagnosis, and they are less likely to provide any psychosocial treatment or follow up care (Hoagwood, et al., 1998).

Behavioural treatment approaches involve training parents and teachers how to effectively use such techniques as "time out", point systems and contingent attention in managing the behaviour of ADHD children. When delivered by highly skilled therapists, such behavioural training for both parents and teachers is effective, though resource intensive. In a recent large scale NIMH study, the addition of behavioural treatment to treatment with stimulant medications provided some benefits in addition to the effectiveness of carefully managed and monitored stimulant medication by itself, such as improved parent child relations, increased satisfaction by parents and children, improved school achievement, and decreased aggressive behaviour (MTA Cooperative Group, 1998).

In general, there are not sufficient skilled professionals available in child and youth mental health services in the province to provide much of behavioural treatment for ADHD children; to be effective, the treatment requires more time and resources than are generally available.

Disruptive disorders

What are disruptive disorders?

Disruptive disorders, such as oppositional defiant disorder and conduct disorder, are characterized by antisocial behaviours in childhood, delinquent and criminal activity in adolescence.

Children who develop the more serious conduct disorders often show signs of these disorders at an earlier age and are diagnosed with Oppositional Defiant Disorder (ODD). ODD is characterized by such problem behaviors as persistent fighting and arguing, being touchy or easily annoyed, and deliberately annoying or being spiteful or vindictive to other people.

Children with ODD may repeatedly lose their temper, argue with adults, deliberately refuse to comply with requests or rules of adults, blame others for their own mistakes, and be repeatedly angry and resentful. Stubbornness and testing of limits are common. These behaviors cause significant difficulties with family and friends and at school or work (DSM-IV; Weiner, 1997). Oppositional defiant disorder is sometimes a precursor of conduct disorder (DSM-IV).

In different studies, estimates of the prevalence of ODD have ranged from 1 to 6 percent, depending on the population sample and the way the disorder was evaluated, but not depending on diagnostic criteria. Before puberty, the condition is more common in boys, but after puberty the rates in both genders are equal.

Marital discord, disrupted child care with a succession of different caregivers, and inconsistent, unsupervised child-rearing contribute to the condition.

Children or adolescents with conduct disorder behave aggressively by fighting, bullying, intimidating, physically assaulting, sexually coercing, and/or being cruel to people or animals. Vandalism with deliberate destruction of property, for example, setting fires or smashing windows, is common, as are theft; truancy; and early tobacco, alcohol, and substance use and abuse; and precocious sexual activity. Girls with a conduct disorder are prone to running away from home and may become involved in prostitution. The behavior interferes with performance at school or work, so that individuals with this disorder rarely perform at the level predicted by their IQ or age. Their relationships with peers and adults are often poor. They have higher injury rates and are prone to school expulsion and problems with the law. Sexually transmitted diseases are common. If they have been removed from home, they may have difficulty staying in an adoptive or foster family or group home, and this may further complicate their development. Rates of depression, suicidal thoughts, suicide attempts, and suicide itself are all higher in children diagnosed with a conduct disorder (Shaffer et al., 1996b).

The prevalence of conduct disorder in 9 to 17-year-olds in the community varies from 1 to 4 percent, depending on how the disorder is defined (Shaffer et al., 1996a). Those with early onset have a worse prognosis and are at higher risk for adult antisocial personality disorder (DSM-IV; Rutter & Giller, 1984; Hendren & Mullen, 1997). Between a quarter and a half of highly antisocial children become antisocial adults.

Social risk factors for conduct disorder include early maternal rejection, separation from parents with no adequate alternative caregiver available, early institutionalization, family neglect, abuse or violence, parents' psychiatric illness, parental marital discord, large family size, crowding, and poverty (Loeber & Stouthamer-Loeber, 1986). These factors are thought to lead to a lack of attachment to the parents or to the family unit and eventually to lack of regard for the rules and

rewards of society (Sampson & Laub, 1993). Physical risk factors for conduct disorder include neurological damage caused by birth complications or low birth weight, attention-deficit/hyperactivity disorder, fearlessness and stimulation-seeking behavior, learning impairments, autonomic underarousal, and insensitivity to physical pain and punishment. A child with both social deprivation and any of these neurological conditions is most susceptible to conduct disorder (Raine et al., 1998).

Since many of the risk factors for conduct disorder emerge in the first years of life, intervention must begin very early. Recently, screening instruments have been developed to enable earlier identification of risk factors and signs of conduct disorder in young children (Feil et al., 1995). Studies have shown a correlation between the behavior and attributes of 3-year-olds and the aggressive behavior of these children at ages 11 to 13 (Raine et al., 1998). Measurements of aggressive behaviors have been shown to be very stable over time (Sampson & Laub, 1993).

Treatment of disruptive disorders

Several psychosocial interventions have been shown to be reasonably effective in reducing antisocial behaviour in children with disruptive disorders (Brestan & Eyberg, 1998).

Behavioural treatment approaches that involve social skills training for children and intensive training for parents in better managing their children's behaviour have been well researched and are generally effective (e.g., Patterson, et al., 1993). Such treatment programs are being used in the province (e.g., in Saskatoon, Child and Youth Services in cooperation with school boards provides such treatment service in about 25 schools).

Multisystemic therapy, developed more recently, is an intensive, short-term, home-and family-focused treatment approach that combines behavioural and other family interventions effectively for difficult conduct disordered youth in the justice system (Henggeler et al., 1998). The approach is resource intensive with interventions directly in the youth's family, peer group, school, and neighborhood by identifying and targeting factors that contribute to the youth's problem behaiours. The main goal is to develop skills in both parents and community organizations affecting youth that will last after brief (4 months) and intensive treatment. Elaborate clinical training of therapists, supervision, and monitoring of treatment adherence make this an exemplary approach. Research has shown it to be more effective than usual community services and than individual therapy in reducing criminal offences and improving family relations.

A well-planned program relying on multisystemic therapy has just been initiated at the Randall Kinship Centre focusing on Aboriginal young offenders in the core area of Regina. The program has low caseloads, well trained staff including Aboriginals, is designed to be culturally sensitive, and is embedded in the community with many linkages. An evaluation of this promising new program will be carried out. If initial evaluations are positive, this is the kind of model program which warrants implementation across the province.

Substance Use Disorders in Adolescents

Since the early 1990s there has been a "sharp resurgence" in the misuse of alcohol and other drugs by adolescents (Johnston et al., 1996). A recent review, focusing particularly on substance abuse and dependence, synthesizes research findings of the past decade (Weinberg et al., 1998).

According to the National Comorbidity Study in the U.S., 41 to 65 percent of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51 percent of those with one or more lifetime mental disorders also have a lifetime history of at least one substance use disorder (Kessler et al., 1996). The rates are highest in the 15- to 24-year-old age group (Kessler et al., 1994). The cross-sectional data on association do not permit any conclusion about causality or clinical prediction (Kessler et al., 1996), but an appealing theory suggests that a subgroup of the population abuses drugs in an effort to self-medicate for the co-occurring mental disorder.

Treatment of substance abuse

Family-oriented therapies appear to be superior to other treatment approaches and enhance the effectiveness of other treatments (Stanton & Shadish, 1997). Multisystemic family therapy, as discussed earlier for disruptive disorders, is also effective in reducing alcohol and other substance use among adolescents (Pickrel & Henggleler, 1996).

Depression and suicide in youth

Depressive disorders are inevitably associated with personal distress, and if they last a long time or occur repeatedly, they can lead to a circumscribed life with fewer friends and sources of support, more stress, and missed educational and job opportunities (Klein et al., 1997). The psychological scars of depression include an enduring pessimistic style of interpreting events, which may increase the risk of further depressive episodes. Untreated and prolonged depression in children and youth is a prime risk factor for suicide. Suicide is the second leading cause of death, after transport accidents, in 15-34 year olds in the developed regions of the world (WHO, 2000). In a 10- to 15-year follow up study of 73 adolescents diagnosed with major depression, 7 percent of the adolescents had committed suicide sometime later. The depressed adolescents were five times more likely to have attempted suicide as well, compared with a control group of age peers without depression (Weissman et al., 1999).

Treatment of childhood depression

Cognitive behaviour therapy, which is discussed later for adult anxiety and depression, has been shown to be quite effective for children suffering from depression (Kaslow & Thomson, 1998).

Tricyclic antidepressants, based on their effectiveness for depression in adults, were the medications of choice in treating depression in children. However, at least 13 distinct trials in children and adolescents have now failed to demonstrate their efficacy. Though not yet adequately evaluated, SSRIs are now thought to be the medications of choice by physicians.

Services for Children and Youth

Mental disorders and mental health problems appear in families of all social classes and of all backgrounds. No one is immune. Yet there are children who are at greatest risk by virtue of a broad array of factors. These include physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect.

The most severely and persistently mentally impaired (SPMI) children and youth, those with multiple disorders and problems who comprise about 2-3% of all children, are especially poorly served in the province. A continuum of services is not normally available for SPMI children, i.e.,

an integrated continuum of case management, day treatment, alternate residences, and in-patient treatment. These youth are often "locked up" in adult mental health units at times of crisis, often come under the care of Social Services, often end up in secure custody youth facilities in Corrections.

The need for better integrated services for mentally disordered children and youth, integrated across the mental health, educational, social services, and corrections sectors, continues to present a critical challenge, addressed in part by the Integrated Services Forum in Government. More is required.

Preventive interventions have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social and emotional development by providing, for example, educational programs for young children, parent-education programs, and nurse home visits.

Primary care and the schools are major settings for the potential recognition of mental disorders in children and adolescents, yet trained staff are very limited in the province, as are options for referral to specialty care.

The multiple problems associated with "serious emotional disturbance" in children and adolescents are best addressed with a "systems" approach in which multiple service sectors work in an organized, collaborative way. Research on the effectiveness of systems of care shows positive results for system outcomes and functional outcomes for children; however, the relationship between changes at the system level and clinical outcomes is still unclear.

Cultural differences exacerbate the general problems of access to appropriate mental health services. Culturally appropriate services for Aboriginal children and families have been designed but are not widely available in the province.

Adults

Treatment of Anxiety Disorders

The anxiety disorders are treated with some form of counseling or psychotherapy or pharmacotherapy, either singly or in combination (Barlow & Lehman, 1996; March et al., 1997; American Psychiatric Association, 1998; Kent et al., 1998). Anxiety disorders are responsive to counseling and to a variety of psychotherapies. More severe and persistent symptoms also may require pharmacotherapy (American Psychiatric Association, 1998).

During the past several decades, there has been increasing enthusiasm for more focused, time-limited therapies that address ways of coping with anxiety symptoms more directly rather than exploring unconscious conflicts or other personal vulnerabilities (Barlow & Lehman, 1996). These therapies typically emphasize cognitive and behavioral assessment and interventions.

The hallmarks of cognitive-behavioral therapies are evaluating apparent cause and effect relationships between thoughts, feelings, and behaviors, as well as implementing relatively straightforward strategies to lessen symptoms and reduce avoidant behavior (Barlow, 1988). A critical element of therapy is to increase exposure to the stimuli or situations that provoke anxiety. Without such therapeutic assistance, the sufferer typically withdraws from anxiety-inducing situations, inadvertently reinforcing avoidant or escape behavior.

There is now extensive evidence that cognitive-behavioral therapies are useful treatments for a majority of patients with anxiety disorders (Chambless et al., 1998). For example, in a meta-analysis of research published between 1974-1994, researchers compared controlled trials of cognitive-behaviour therapy and pharmacological treatment for patients with panic disorder. While both treatments were effective in the short-term, the results were more positive and longer lasting for cognitive-behaviour therapy (Clinical Psychology Review, 1995).

With pharmaceutical costs rising dramatically in the country and accounting for 16% ($14.7 billion) of total healthcare expenditures in 2000 (CIHI), evidence-based alternative treatments for anxiety and depression are increasingly being sought by health care providers. Psychological brief treatments, such as cognitive-behaviour therapy, are cost-effective (American Psychological Association, 2001).

Poorer outcomes are observed, however, in more complicated patient groups. With obsessive-compulsive disorder, approximately 20 to 25 percent of patients are unwilling to participate in therapy (March et al., 1997).

The major limitation of cognitive-behavioral therapies is not their effectiveness, but rather the limited availability of skilled practitioners (Ballenger et al., 1998; U.S. Surgeon General, 1999). The shortage of skilled therapists in Saskatchewan is severe.

It is possible that more traditional forms of therapy based on psychodynamic or interpersonal theories of anxiety also may prove to be effective treatments (Shear, 1995). However, these therapies have not yet received extensive empirical support. As a result, more traditional therapies are generally deemphasized in evidence-based treatment guidelines for anxiety disorders.

Treatment of Mood Disorders

So much is known about the assortment of pharmacological and psychosocial treatments for mood disorders that the most salient problem is not with treatment, but rather with getting people into treatment.

Cognitive-behaviour therapy is the most frequently used evidence-based psychological treatments for depression. Drug therapy alone has been shown to have a higher dropout rate and a higher rate of relapse, whereas cognitive-behaviour therapy used alone or in conjunction with short-term pharmacotherapy can prevent relapse and re-hospitalization for many patients. Again, access to cognitive-behaviour therapy is extremely limited in Saskatchewan.

Surveys consistently document that a majority of individuals with depression receive no specific form of treatment (Katon et al., 1992; Narrow et al., 1993; Wells et al., 1994; Thase, 1996). Nearly 40 percent of people with bipolar disorder are untreated in one year, according to the U.S. Epidemiologic Catchment Area survey (Regier et al., 1993b). Undertreatment of mood disorders stems from many factors, including societal stigma, financial barriers to treatment, under recognition by health care providers, and under appreciation by consumers of the potential benefits of treatment, and a shortage of skilled therapists in the province (e.g., Regier et al., 1988; Wells et al., 1994; Hirschfeld et al., 1997). The symptoms of depression, such as feelings of worthlessness, excessive guilt, and lack of motivation, also deter consumers from seeking treatment; and Aboriginal people as well as members of ethnic minority groups often encounter special barriers.

Mood disorders have profoundly deleterious consequences on well-being: their toll on quality of life and economic productivity matches that of heart disease and is greater than that of peptic ulcer, arthritis, hypertension, or diabetes (Wells et al., 1989).

Psychological treatment of anxiety and mood disorders in primary health care

There is a good deal of evidence of the effectiveness of brief psychological interventions such as cognitive-behavioural therapy at primary care and across the continuum of care in treating anxiety and depression. Also, brief psychological treatment can reduce other health professionals' workloads, effectively re-distributing their capacity to perform discipline-specific duties, and reduce costs to the health system (Simon et al., 1995). Among the key findings summarized by the Saskatchewan Psychological Association (2001) are:

- psychological treatment offered at primary care in an on-site and seamless fashion yield utilization rates, outcomes, and patient satisfaction that are much higher than traditional referrals;
- medical utilization rates decline significantly following psychological intervention; psychological treatment has resulted in reductions up to 50% in visits to family physicians alone in study in London, ON (Golden, 1997);
- the large majority of patients can benefit from brief treatment interventions (less than 10 sessions);
- costs savings have been documented to average between 20-30% in 91 different studies (Chiles et al., 1999); even with no direct cost savings, benefits accrue from reduced burden on other medical staff and resources;
- failure to provide adequate psychological treatment encourages somatization and over utilization of other less appropriate and more expensive medical services.

Borderline and Antisocial personality disorders

Personality disorders differ from the other mental disorders reviewed here in that they are thought to reflect an enduring and inflexible pattern of behaviour, one that is typically disruptive to others, and that is not better accounted for by other mental disorders. Among the ten personality disorders that are diagnosed on Axis II of the DSM, borderline and antisocial personality disorders are common and both present difficult management challenges in health and criminal justice settings.

Borderline personality disorder is characterized by marked instability of mood, intense feelings of anger and hostility, repeated episodes of self-mutilation and suicide attempts, and stormy and unstable relationships. A borderline personality pattern usually is diagnosed along with an Axis I mental disorder, commonly mood and anxiety disorders (particularly panic attacks and post-traumatic stress), substance abuse. The co-occurrence of borderline personality disorder and a mood or anxiety disorder frequently means that a patient will respond less favorably to otherwise effective pharmacological and psychological treatments.

While it is estimated that about 2 percent of the adult population may suffer from borderline personality disorder, they represent a disproportionate number of patients in inpatient (about 15%) and outpatient (about 8%) mental health settings (Widiger & Trull, 1993). They are frequently the most "difficult" patients in health care settings—known for their difficult relationships with other patients, their suicide gestures (called parasuicidal behaviour) and high risk for suicide (between 6-9% do kill themselves), for their non-compliance with treatments and the difficult challenges their hostility and parasuicidal behavior presents to therapists.

A borderline personality pattern typically emerges in young adulthood along with failures in education, employment and relationships. Severely dysfunctional family dynamics in childhood are common; well over one-half of borderline patients were victims of physical and/or sexual abuse as children.

Prognosis and treatment prospects are quite guarded. Antidepressant, antibipolar, and newer atypical antipsychotic medications have helped some to calm their emotional and aggressive storms (e.g., Davis et al, 2000). The most widely practiced psychotherapy, dialectical behaviour therapy (Linehan, 1993a; 1993b), while highly regarded by clinicians and promising has not yet been adequately evaluated in controlled clinical trials. It is a multi-faceted and intensive therapeutic approach, requiring at least one year of weekly sessions and regular follow-ups. Only very skilled therapists, typically working in a team that provides support and supervision, are likely to be able to apply this therapy successfully.

Antisocial personality disorder and the closely related disorder of psychopathy is the mental disorder most closely linked to adult criminal behaviour. Antisocial personality disorder is characterized by inadequate conscience development, irresponsible and impulsive behaviour, rejection of authority, ability to impress and exploit others, and an inability to maintain good relationships. Epidemiological surveys indicate that up to 3 percent of people meet diagnostic criteria for antisocial personality disorder (Kessler et al., 1994). Higher rates of alcohol and other substance-related disorders are found in those with antisocial personality disorder than in the population (Myers et al, 1998).

Antisocial personality is best understood as developing over the course of childhood and adolescence, with early indications seen in oppositional defiant disorder and or ADHD in young children and conduct disorder in adolescence. There is growing evidence that genetic propensities leading to mild neuropsychological problems and emotional deficits and a difficult childhood temperament are predispositions in the development of antisocial personality. Such biological predispositions in combination with dysfunctional family dynamics (parental absence, rejection, aggression, and inconsistency) lead to antisocial and criminal behaviour in young adulthood.

Research on the efficacy of treatment for adults with antisocial personality disorder, most often in treatment programs in correctional facilities, has not found solid evidence in support of any treatment program. Most of today's treatment approaches have little or no impact on people with antisocial personality disorder or psychopathy. Nor have any pharmacological treatments fared much better. Multifaceted and intensive cognitive-behavioural treatment programs offer some promise (Losel, 1998; Rice & Harris, 1997), particularly in treating young offenders.

Perhaps the best answer in addressing the considerable social problems of crime posed by those with antisocial personality disorder is to be found in increased investments "upstream" in prevention programs targeted at children and youth at highest risk for conduct disorder (e.g., Reid & Eddy, 1997). The Kids First initiative in the province is a good example of such a primary prevention program.

Schizophrenia and serious mental illnesses

Despite the variability, some generalizations about the long-term course of schizophrenia are possible, based on longitudinal research. A small percentage (10 percent or so) of patients seem to remain severely ill over long periods of time (Jablensky et al., 1992; Gerbaldo et al., 1995). Most do not return to their prior state of mental function. Yet several long-term studies reveal that about one-half to two-thirds of people with schizophrenia significantly improve or recover, some completely (for a review see Harding et al., 1992). These studies are important because they help to dispel the traditional view, dating back to the 19th century, that schizophrenia had a uniformly downhill course (Harding et al., 1992). Several other longitudinal studies, however, have found less favorable patient outcomes with other cohorts of patients (Harrow et al., 1997). The differences in outcomes between various studies are thought to be explained on the basis of differences in patient age, length of follow up, expectations about prognosis, and types of services received (Harrow et al., 1997).

The importance of a rehabilitation focus in shaping patient outcome was supported by one of the only direct comparisons between patient cohorts. The Vermont cohort consisted of the most severely affected patients from the "back wards" of the state hospital (Harding et al., 1987). As part of a program of deinstitutionalization, the cohort was released in the 1950s to a hospital-based rehabilitation program and then to what was at the time an innovative, broad-based community rehabilitation program, which incorporated social, residential, and vocational components. Patients' degree of recovery at follow up after three decades was measured by global functional improvement and other functional measures. One-half to two-thirds of the Vermont cohort significantly improved or recovered (Harding et al., 1987). The receipt of community-based rehabilitation was considered key to their recovery on the basis of a study comparing their progress with that of a matched cohort of deinstitutionalized patients from Maine. The Maine cohort did not function as well after receiving more traditional aftercare services without a rehabilitation emphasis (DeSisto et al., 1995a, 1995b).

Although the findings from the Vermont cohort, as well as those from a cohort in Switzerland (Ciompi, 1980), are widely cited by consumers as evidence of recovery from mental illness, it bears noting that patients in the Vermont cohort represented a less rigorously defined conceptualization of schizophrenia than is common today, which may account, in part, for the more favorable outcomes.

Schizophrenia does not follow a single pathway. Rather, like other mental and somatic disorders, course and recovery are determined by a constellation of biological, psychological, and sociocultural factors. That different degrees of recovery are attainable has offered hope to consumers and families.

Assertive Community Treatment for schizophrenia

Assertive community treatment is an intensive approach to the treatment of people with serious mental illnesses that relies on provision of a comprehensive array of services in the community. The model originated in the late 1970s with the Program of Assertive Community Treatment in Madison, Wisconsin (Stein & Test, 1980). Fueled by deinstitutionalization and the vital need for community-based services, a multidisciplinary team serving psychiatric inpatients adapted its role to patients in the community. For this reason, assertive community treatment often is likened to a "hospital without walls."

The hallmark of assertive community treatment is an interdisciplinary team of usually 10 to 12 professionals, including case managers, a psychiatrist, several nurses and social workers, vocational specialists, and more recently includes substance abuse treatment specialists and peer specialists. Assertive community treatment also includes these features: coverage 24 hours, 7 days per week; comprehensive treatment planning; ongoing responsibility; staff continuity; and small caseloads, most commonly with 1 staff member for every 10 clients (Scott & Dixon, 1995). Because of the intensity of services, assertive community treatment is most cost-effective when targeted to individuals with the greatest service need, particularly those with a history of multiple hospitalizations (Scott & Dixon, 1995; Lehman & Steinwachs et al., 1998).

Randomized controlled trials have demonstrated that assertive community treatment and similar models of intensive case management substantially reduce inpatient service use, promote continuity of outpatient care, and increase community tenure and residence stability for people with serious mental illnesses (Stein & Test, 1980; Bond et al., 1995; Lehman, 1998; Mueser et al., 1998a). Among the beneficiaries are homeless individuals, and those with substance abuse problems and mental disorders. Evidence of effectiveness is weaker for other outcomes (e.g., social integration, employment) and for amelioration of substance abuse problems associated with schizophrenia, particularly when combined treatment is not offered (Mueser et al., 1998b). Assertive community treatment models are generally popular with clients (Stein & Test, 1980) and family members (Flynn, 1998). There also are some preliminary results suggesting that employing peer (i.e., consumer) or family outreach workers on the multidisciplinary assertive community treatment teams increases positive outcomes (Dixon et al., 1997, 1998) and creates more positive attitudes among team members toward people with mental illnesses.

The Phoenix Residential Society in Regina provides a combination of assertive community treatment, as well as residential services, supported housing, and community supports. It provides services to about 90 residents, including a residential treatment program for 10 individuals with a dual diagnosis of mental illness and substance abuse.

Early intervention programs for schizophrenia

Early psychosis intervention is a promising model starting to be implemented in Canada (CMHA, 2001c). Early intervention programs typically provide low-dose antipsychotic medications, psychoeducation for the youth and their family, and support for the development of coping skills as early as possible when symptoms first appear in adolescence. Research shows this strategy can reduce disruption of relationships, reduce likelihood of hospitalization and relapse, and improve the capacity for young people to maintain their life course (Edwards et al., 2000). Focusing efforts at this stage can help curtail demand later on.

Best practice guidelines (CMHA, 2001) for early psychosis intervention programs include: timely access, comprehensive assessment, multidisciplinary team treatment, family education and support, support for reintegration into school and work, and awareness building and education for primary health care providers.

Such an early psychosis intervention service has been provided in Saskatoon since 1999 under the direction of Dr. S Shrinkhande and two community mental health nurses. Compared to ten other programs across Canada, as reviewed by CMHA (2001), the staffing and other resources available to the program in Saskatoon are minimal.

Services for the severely mentally disabled

Work done for the Federal/Provincial/Territorial Advisory Network on Mental Health (Health Systems Research Unit, 1997) has identified best practices in services for the seriously mentally ill, following a situation analysis of best practice policies and initiatives across Canada. The best practices are grouped in three levels: cornerstones of mental health policy reform; best practices in reform of mental health systems; and best practices in programs and services. The recognized best practices include:

Cornerstones of mental health policy reform

- Correcting the historical imbalance between institutional and community-based care
- Offering a comprehensive range of services – treatment, rehabilitative, preventive and promotional
- Developing governance of health/mental health services at the regional/local level to make the system responsive to local needs
- Recognizing that mental health care should not be limited to formal mental health supports
- Acknowledging consumers and families as critical partners in planning, delivering and evaluating mental health care delivery

Best Practices in System Reform

- A free standing mental health policy supported by an explicit vision and timetable for implementation; preservation of the mental health funding envelope; increased funding for community care
- Mental health authorities at regional or local levels with a single funding envelope that can be used flexibly; consumer-centered planning, funding and management
- Comprehensive monitoring, use of performance indicators, evaluation and accountability frameworks, and continuous quality improvement
- A detailed labour strategy for service provision, and strategies to enhance consumer involvement

Best Practices in Mental Health programs and services

- Assertive Community Treatment programs for improving clinical status and reducing hospitalization, as considered above.
- Crisis response programs which divert people from inpatient hospitalization
- A range of different housing alternatives, along with a shift in resources and emphasis to supported housing (using generic housing widely dispersed in the community, with flexible individualized supports)
- Long stay hospital patients moved from psychiatric hospitals to community with carefully planned transitions to alternative care models such as home treatment and day hospital
- Self-help and other consumer-run initiatives funded and nurtured; funding for family engagement and participation
- A shift from traditional vocational services to supported employment, with continuous individual support and attention to consumer preferences and supported education

- Early detection and intervention for at risk individuals
- Primary care that links family physicians to community mental health services

Older Adults

Depression and Suicide

The most serious consequence of depression in later life—especially untreated or inadequately treated depression—is increased mortality from either suicide or somatic illness. Older persons (65 years and above) have the highest suicide rates of any age group. The suicide rate for individuals age 85 and older is the highest, at about 21 suicides per 100,000, a rate almost twice the overall rate of 10.6 per 100,000 in the U.S. (CDC, 1999). The high suicide rate among older people is largely accounted for by white men, whose suicide rate at age 85 and above is about 65 per 100,000 (CDC, 1999). Trends from 1980 to 1992 reveal that suicide rates are increasing among more recent cohorts of older persons (Kachur et al., 1995). Since statistics are unlikely to include more veiled forms of suicide, such as nursing home residents who stop eating, estimates are probably conservative.

Suicide in older adults is most associated with late-onset depression: among patients 75 years of age and older, 60 to 75 percent of suicides have diagnosable depression (Conwell, 1996). Using a "psychological autopsy," Conwell and coworkers investigated all suicides within a geographical region and found that with increasing age, depression was more likely to be unaccompanied by other conditions such as substance abuse (Conwell et al., 1996). While thoughts of death may be developmentally expected in older adults, suicidal thoughts are not. From a stratified sample of primary care patients over age 60, Callahan and colleagues estimated the prevalence of specific suicidal thoughts at 0.7 to1.2 percent (Callahan et al., 1996). Unfortunately, no demographic or clinical variables distinguished depressed suicidal patients from depressed nonsuicidal patients (Callahan et al., 1996).

Swedish researchers found much higher rates of suicidal ideation after interviewing adults aged 85 years and older. They found a 1-month prevalence of any suicidal feelings in 9.6 percent of men and 18.7 percent of women (Skoog et al., 1996). Suicidal feelings were strongly associated with depression. For example, 6.2 percent of the participants who did not meet criteria for depression or anxiety reported suicidal thoughts, while almost 50 percent of those meeting criteria for depression reported such thoughts. The higher prevalence of suicidal feelings in this study, compared with the U.S. study cited earlier, is likely due to the older age of subjects and to methodological differences.

Studies of older persons who have committed suicide have revealed that older adults had seen their physician within a short interval of completing suicide, yet few were receiving mental health treatment. Caine and coworkers studied the records of 97 adults aged 50 years and older who completed suicide (Caine et al., 1996). Of this group, 51 had seen their primary care physician within 1 month of the suicide. Forty-five had psychiatric symptoms. Yet in only 29 of the 45 individuals were symptoms recognized, in only 19 was treatment offered, and in only 2 of these 19 cases was the treatment rendered considered adequate. Treatment was deemed inadequate if an incorrect medicine (such as a benzodiazepine for severe major depression) or inadequate dose was prescribed. This line of research highlights important opportunities for suicide prevention.

Depression also can lead to increased mortality from other diseases, such as heart disease and possibly cancer. How depression exerts these effects is not yet understood. In nursing home patients, major depression increases the likelihood of mortality by 59 percent, independent of

physical health measures (Rovner, 1993). In the case of myocardial infarction, depression elevates mortality risk fivefold (Frasure-Smith et al., 1993, 1995). Depression also has been linked to the onset of cancer, but results have been inconsistent. Yet a new epidemiological study, considered the most compelling to date, finds that chronic depression (lasting an average of about 4 years) raises the risk of cancer by 88 percent in older people (Penninx et al., 1998). Thus, increased understanding of depression in older people may be, literally, a matter of life and death.

The high prevalence of depressive syndromes and symptoms in older adults exacts a large economic toll. Depression as a whole for all age groups is one of the most costly disorders in Canada and the U.S. (Hirschfeld et al., 1997). Late-life depression is particularly costly because of the excess disability that it causes and its deleterious interaction with physical health. Older primary care patients with depression visit the doctor and emergency room more often, use more medication, incur higher outpatient charges, and stay longer at the hospital (Callahan et al., 1994; Cooper-Patrick et al., 1994; Callahan & Wolinsky, 1995; Unutzer et al., 1997).

Alzheimer's Disease and other Dementias

Alzheimer's disease strikes 8-15% of people over the age of 65 (Ritchie & Kildea, 1995), with rates doubling every five years after age 60 (Jorm et al., 1987). Memory loss is not the only impairment. Symptoms extend to other cognitive impairments in language and executive functioning; behavioural symptoms such as psychosis, agitation, and wandering are common and impose tremendous strain on caregivers. Alzheimer's disease and related other dementias lead to significant dependency and is a leading contributor to the need for costly long-term care in the last years of life. As our population ages, the growing number of patients with Alzheimer's disease is likely to have significant public health and economic consequences. In Saskatchewan, about one-third of all patients currently in long-term care facilities suffer from Alzheimer's disease (Stewart, 1998).

Treatment Services for Depression, Dementias, and other Severe and Persistent Mental Disorders

Older adults with severe and persistent mental disorders (SPMD) are the most frequent users of long-term care either in community or institutional settings. SPMD in older adults includes lifelong and late-onset schizophrenia, delusional disorder, bipolar disorder, and recurrent major depression. I t also includes Alzheimer's disease and other dementias (and related behavioral symptoms, including psychosis), severe treatment-refractory depression, or severe behavioral problems requiring intensive and prolonged psychiatric intervention. Although these groups of disorders have different courses of illness and outcomes, they have many overlapping clinical features, share the common need for mental health long-term care services, and are frequently treated together in long-term care settings (Burns, 1991; Gottesman et al., 1991; American Psychiatric Association, 1993). It is estimated that 0.8 percent of persons older than 55 years in the United States have SPMD (Kessler et al., 1996), perhaps about 9,000 older adults in Saskatchewan.

Older adults with SPMD are high users of services (Cuffel et al., 1996; Semke & Jensen, 1997) and require mental health long-term care that is comprehensive, integrated, and multidisciplinary (Moak, 1996; Small et al., 1997; Bartels & Colenda, 1998). The mental health care needs of this population include specialized geropsychiatric services (Moak, 1996); integrated medical care (Moak & Fisher, 1991; Small et al., 1997); dementia care (Small et al., 1997; Bartels & Colenda, 1998); home and community-based long-term care; and residential and family support services, intensive case management, and psychosocial rehabilitation services (Aiken, 1990; Robinson,

1990; Schaftt & Randolph, 1994; Lipsman, 1996). With adequate supports, older persons with SPMD can be maintained in the community, sometimes at lower cost, and with equal or improved quality of life in comparison with institutions (Bernstein & Hensley, 1988; Mosher-Ashley, 1989; Leff, 1993; Trieman et al., 1996).

However, our mental health system has left many older persons with SPMD with decreased access to mental health care in both community and institutional settings (Knight et al., 1998). Community-based mental health services for older people are largely provided through the general medical sector, partly due to poor responsiveness to the needs of older people by community mental health organizations (Light et al., 1986). Yet reliance on the general medical sector also has not met their needs because of its focus on acute care (George, 1992). In addition, most home health agencies provide no or very limited short-term mental health care. The long-term care programs that exist primarily aid older adults with chronic physical disabilities or cognitive impairment but fail to address impairments in mood and behavior (Robinson, 1990). An additional barrier is that the majority of community-residing older adults do not seek mental health services, except for medication (Meeks & Murrell, 1997), despite continued need (Meeks et al., 1997). Those without family support generally live in nursing homes, assisted living facilities, and board and care homes. These three are forms of residential care that offer some combination of housing, supportive services, and, in some cases, medical care. In short, more resources must be devoted to programs that integrate mental health rehabilitative services into long-term care in both community and institutional settings.

New Perspectives on Services for Older Adults

New perspectives are evolving on the nature of mental health services for older adults and the settings in which they are delivered. Far greater emphasis is being placed on community-based care, which entails care provided in homes, in outpatient settings, and through community organizations. The emphasis on community-based care has been triggered by a convergence of demographic, consumer, and public policy imperatives. In terms of demographics, approximately 95 percent of older persons at a given point in time live in the community rather than in institutions, such as nursing homes (U.S. Department of Health and Human Services, Administration on Aging, and American Association of Retired Persons, 1995). Of those living in the community, approximately 30 percent, mostly women, live alone (U.S. DHHS, AoA & AARP, 1995). Most older persons prefer to remain in the community and to maintain their independence. Yet living alone makes them even more reliant on community-based services if they have a mental disorder.

Service delivery also is being shaped by public policy. The escalating costs of institutional care, combined with the recognition of past abuses, are stimulating policies to limit nursing home admissions and to shift treatment to the community (Maddox et al., 1996). Mental disorders are leading risk factors for institutionalization (Katz & Parmelee, 1997). Therefore, to keep older people in the community, where they prefer to be, more energies are being marshaled to promote mental health and to prevent or treat mental disorders in the community. In other words, treating mental disorders is seen as a means to stave off costly institutionalization—resulting either from a mental disorder or a comorbid somatic disorder. An untreated mental disorder, for example, can turn a minor medical problem into a life-threatening and costly condition. Problems with forgetting to take medication (e.g., with dementia), developing delusions about medication (e.g., with schizophrenia), or lowering motivation to refill prescriptions (e.g., with depression) can increase the likelihood of having more severe illnesses that demand more intensive and expensive institutional care. Therefore, promotion of mental health and treatment of mental disorders are crucial elements of service delivery.

The delivery of community-based mental health services for older adults faces an enormous challenge. Services for older adults are insufficient and fragmented, often divided between systems of health, mental health, and social services (Gatz & Smyer, 1992; Cohen & Cairl, 1996). Under these three systems, services include medical and psychosocial care, rehabilitation, recreation, housing, education, and other supports.

There is no administrative body responsible for integrating the daunting array of services needed specifically for individuals with severe mental illnesses. Similar problems are encountered with coordinating services for children and youth as discussed earlier. The fragmentation of service systems for older people in the province stands in some contrast to the United Kingdom and Ireland, where governmental authorities coordinate their care (Reifler, 1997).

Demographic, consumer, and public policy imperatives will propel tremendous growth in the diversity of settings in which older persons simultaneously reside and receive care. Care may no longer be the strict province of home or nursing home. The diversity of home settings likely in suburban and urban communities extends from naturally occurring retirement communities to continuing care retirement communities to other types of alternative living arrangements. These settings include congregate or senior housing, senior hotels, foster care, group homes, day centers (where people reside during the day), and others. The diversity of institutional settings includes nursing homes, general hospitals (with and without psychiatric units), psychiatric hospital beds, among others. In fact, the range of settings, and the nature of the services provided within each, will blur the distinction between home and nursing home (Kane, 1995).

Across the range of settings, the duration of care can be short term or long term, depending on the patient's needs. The phrase, "long-term care," has come to refer to a range of services for people with chronic or degenerative illness or disabilities who require support over a prolonged period of time. In the past, long-term care was synonymous with nursing home care or other forms of institutional care, but the term will increasingly come to apply to a full complement of institutional or community-based settings.

Within the continuum of services, one new perspective—conceived as the landscape for aging—strives to tailor the environment to the needs of the person through a combined focus on health and residential requirements (Cohen, 1994). Whether at home, in a retirement community, or in a nursing home, this health and home perspective is deemed to be crucial to achieving high quality of life for older adults. Over recent years, improvements in the health side of this perspective have occurred, but the home part has lagged. The challenge is to stimulate an interdisciplinary collaboration between systems of care and consumers.

A critical area for an interdisciplinary approach is the extent to which a given setting fosters independent functioning versus dependent functioning, an issue influencing mental health and quality of life. Though certainly not a goal, many settings inadvertently foster dependency rather than independence. Nursing homes and hospitals, for example, are understandably more focused on what individuals cannot do, as opposed to what they can do. Yet their major focus on incapacity (the nursing and health focus) runs the risk of overshadowing function and independence (the home and humanities focus). In other settings, the balance between dependence and independence shifts in the other direction, with the risk of nursing and health needs being inadequately addressed. In the years ahead, the emphasis will be on "aging in place", either at home or in the community, rather than in alternate settings.

Primary Care. Primary care is a pivotal setting for the identification and treatment of mental disorders in older people. Many older people prefer to receive mental health treatment in primary care (Unutzer et al., 1997), a preference bolstered by current policies that encourage increasing reliance on primary, rather than specialty, mental health care (Mechanic, 1998). Primary care offers the potential advantages of proximity, affordability, convenience, and coordination of care for mental and somatic disorders, given that comorbidity is typical.

The potential advantages of primary care, however, have yet to be realized. Diagnosis and treatment of older people's mental disorders in the primary care setting are inadequate. The efficacious treatments for depression described earlier are not being practiced in primary care and other general medical settings. As noted earlier, a significant percentage of older patients with depression are underdiagnosed and undertreated. The concern about inadequate treatment of late-life depression in primary care is magnified by growing use of nursing homes.

The primary care system is generally not well equipped to treat chronic mental disorders such as depression or dementia. It has limited capacity to identify patients with common mental disorders and to provide the proactive follow up that is required to retain patients in treatment. To ensure better treatment of late-life depression in primary care, there is heightening awareness of the need for new models for mental health service delivery (Unutzer et al., 1997). New models of service delivery in primary care include mental health teams, consultation-liaison models, and integration of mental health professionals into primary care (Katon & Gonzales, 1994; Schulberg et al., 1995; Katon et al., 1996, 1997; Stolee et al., 1996; Gask et al., 1997). For example, the intervention developed by Katon and colleagues introduced a structured depression treatment program into the primary care setting. The program included behavioral treatment to inculcate more adaptive coping strategies and counseling to enhance compliance with antidepressant medications. Patients were randomized in a controlled trial comparing this structured depression program with usual care by primary care physicians. The investigators found patients participating in the program to have displayed better medication adherence, better satisfaction with care, and a greater decrease in severity of major depression (Katon et al., 1996).

Models that integrate mental health treatment into primary care, while thus far designed largely for depression, also may have utility for other mental disorders seen in primary care. Nevertheless, primary care is not appropriate for all patients with severe and persistent mental disorders.

Nursing Homes. Most older adults live in the community and only a minority of them live in nursing homes; of the latter, about two-thirds have some kind of mental disorder (Burns, 1991). The majority have some type of dementia, while others have disabling depression or schizophrenia (Burns, 1991). Despite the high prevalence of people with mental disorders in nursing homes, these settings generally are ill equipped to meet their needs (Lombardo, 1994).

Deinstitutionalization of our mental hospitals in the 1960s encouraged the expanded use of nursing homes for older adults with mental disorders. But the shift to nursing homes was not accompanied by alterations in care.

In 1986, the Institute of Medicine in the U.S. issued a landmark report documenting inappropriate and inadequate care in nursing homes there, including the excessive use of physical and chemical restraints (IOM, 1986). Nursing homes must have the capacity to deliver mental health care. Such capacity depends on trained mental health professionals to deliver appropriate care and treatment.

Home Care. The CMHA, Weyburn Branch (2001) found that in many cases people with serious mental illness are not eligible for home care services unless they are admitted for a physical condition or intellectual disability. Home care services that are available to the mentally ill do not usually involve any mental health care. While a number of RPNs are employed in home care in the province, their job descriptions do not normally include any mental health care; these RPNs may, however, be assigned the more difficult patients that are mentally disordered.

In many cases, adequate home care for mentally ill persons can mean the difference between institutionalization and living in the community.

Chapter Four

Mental Health Workforce in Saskatchewan: Profiles of Professionals and Education and Training Programs

Comprehensive profiles of seven professions providing mental health services in Saskatchewan are presented in this Chapter. First considered are the specialty mental health professions: Registered Psychiatric Nurses, psychologists, and psychiatrists. Profiles of professionals in the general medical/primary care sector are presented next: Registered Nurses, Licensed Practical Nurses, and family physicians/general practitioners. Finally, a profile of social workers, most of who work within the broad human services sector, is presented.

For each profession, the profiles include supply, demographics, employment and practice settings, mental health competencies and services, working conditions (wages, vacancy rates, outmigration). Profiles of the education and training programs for each profession are provided. Issues in each profession are identified.

Paraprofessionals who provide mental health services are briefly considered: addictions counselors, mental health therapists, school counselor, aides, recreational therapists, and the professions occupational therapy and speech and language pathology.

A survey of psychologists, social workers, and other non-regulated counselors who provide private mental health services in the province is presented.

Registered Psychiatric Nurses

A profile of RPNs in Saskatchewan is presented in Appendix 1, including summary information on supply, demographics, mental health services, working conditions, wages, and education and training programs. Some comparison data from other jurisdictions is presented. Issues with respect to the supply of RPNs, training provided in the NEPS, and the uncertain future of the profession are discussed.

Supply. Though the number of RPNs has decreased by 9% from 1997-2000, there are a greater number of RPNs per population in the province (1/916) than in either Manitoba (1/1120) or Alberta (1/2584). In Canada, it is only in the four Western provinces that psychiatric nursing is recognized as a separate profession within nursing. In the rest of the country, RNs work in mental health services (approximately 5% of the RN workforce in Canada, according to CIHI data).

In the past two years only seven new nursing graduates have registered with the RPNAS, compared to an average of 43 per year between 1993-97. This critical issue is considered later in this section.

Location. Registered psychiatric nurses are quite evenly distributed across the province, with more RPNs per population practicing in rural Saskatchewan (1/997) than in Saskatoon (1/1163). The number of RPNs practicing in Regina (1/773) is significantly greater than in the rest of the province.

Age. The average age of RPNs is 42.1 years. On average, RPNs are somewhat younger than RNs and significantly younger than LPNs in the province.

Gender. Sixteen percent of RPNs are male. In comparison, less than 3% of RNs and LPNs are male.

Employment settings and areas of practice. Almost all RPNs are employed in the health sector. About half of the RPNS are employed in the mental health sector in the province; 23% practice in acute care, 11% in care of intellectually disabled, and 10% rehabilitation and vocational services. There are relatively few RPNs practicing in child and youth (4%), and addictions (2%).

In addition to the mental health sector, 28% of all RPNs practice in geriatric or home care, and 8% practice in the forensic area. Mental health problems and disorders are prominent in both the forensic and geriatric sectors of health care. For example, it is estimated that about one-third of the geriatric patients in long-term care suffer from Alzheimer's or other debilitating dementias (Stewart, 2002), and many others are clinically depressed. Thus, the large majority of RPNs can be considered to be providing mental health services.

Working conditions. Vacancy rates for RPN positions in the health sector have increased significantly in the past few years; in 2000 the overall vacancy rate was 5.4%, 7.1% in rural Saskatchewan, compared with a 2-3% vacancy rate in the preceding decade. The turnover rate is also quite high—5.1% in rural areas and 1.7% in Saskatoon and Regina in 2000. Vacancy and turnover rates for RPNs are similar to rates for RNs and somewhat higher than rates for LPNs in Saskatchewan.

RPNs are included with RNs in the Saskatchewan Union of Nurses; wages and salaries are the same for both nurses. The collective bargaining agreement signed between SAHO and SUN in April, 2002, gives nurses at the minimum wage level an increase of about 20% over the three years of the contract. This goes some way toward addressing recruitment and retention issues for nurses.

Comparisons with the other three provinces in Western Canada, presented in Appendix 1 (section 3), show that hourly wages for nurses in Saskatchewan are now about 5% higher than those in Manitoba, and lower than those in both Alberta and BC (7% lower at the minimum wage level, 17% lower at the maximum wage level). Given the lower costs of living in Saskatchewan, wages for nurses here seem to be reasonably competitive with Alberta and BC at the minimum wage level though not at the maximum level. However, new contract negotiations are underway in Alberta which will provide for increased wages effective April, 2003.

Concerns with respect to working conditions of nurses and others employed in the health and mental health sectors in the province were thoroughly reviewed in a recent report (Backman, 2000). These concerns and recommendations to address them are considered in Chapter 5.

Competencies and scope of practice. The RPNAS, in collaboration with its sister associations in the three other Western provinces, has adopted an extensive set of basic competencies for practice in psychiatric nursing (RPNAS, 2001). They are worth highlighting here.

RPNs are expected to possess core competencies in general nursing in such areas biological systems, human growth and development, fundamental nursing skills and processes. The core clinical competencies in mental health for beginning RPNs include:

- knowledge of and ability to work with individuals affected by most of the DSM IV disorders;
- demonstrated knowledge and application of counseling and effective interpersonal communication skills;
- demonstrated knowledge and application of teaching skills;
- demonstrated knowledge and ability to integrate clinical judgment in the pharmacological assessment and treatment of individuals;
- demonstrated knowledge and ability to conduct a comprehensive mental status assessment;
- demonstrated knowledge and ability to conduct a comprehensive psychiatric nursing history;
- demonstrated knowledge and ability to conduct physical assessments and provide physical support to clients;
- demonstrated knowledge and ability to develop and implement a client plan of care;
- demonstrated knowledge and ability to participate in a range of therapeutic modalities, including group therapies, individual therapies, family therapies, milieu therapy, crisis intervention, behaviour therapies;
- demonstrated knowledge and ability to conduct a comprehensive risk assessment and to respond to psychiatric emergencies;
- demonstrated knowledge and ability to identify and access a range of relevant community resources.

Further, these core competencies in mental health (and others not highlighted above) are expected to be developed and applied in a full range of clinical practice areas: addiction services; emergency and crisis services; forensic services; independent practice; community practice; acute care; rehabilitation; child and adolescent services; brain injury services; services for developmentally disabled; services for elderly.

Finally, RPNs are also expected to have a set of competencies beyond direct clinical care, including competencies in mental health in administration, education, consultation, and research.

In the Introduction (RPNAS, 2001), it is stated that all of the above competencies are considered "basic", competencies for beginning practitioners, and are not "advanced" competencies acquired through experience and/or further education. This is a very extensive range of competencies, indeed, more of an ideal than a reality for a beginning psychiatric nurse in the province. The breadth of competencies specified may be misleading. Most other mental health professionals would not consider that such an extensive set of competencies are found in beginning RPNs in sufficient depth for clinical practice.

These competencies should be revised to more accurately reflect the competencies of beginning RPNs. As a good example of beginning competencies for mental health practice in nursing the author suggests the "Exit Profile" developed by the Northern (UK) Centre for Mental Health (2000) which specify behavioural benchmarks for each competency as well as the essential evidence to be used in assessing each benchmark (e.g., observed practice, simulation in skills laboratory, written testimony of others, evidence of learning accomplishments, and others).

Education and training. With the introduction of the Nursing Education Program of Saskatchewan (NEPS) in 1996, specialized two-year diploma training in psychiatric nursing at SIAST's Wascana campus was terminated. In part, this was a response to concerns about a decreasing number of RPN graduates who were being employed full-time in psychiatric nursing. In larger part, it was due to the fact that the RPNAS, after several years of negotiations, joined with the SRNA, SIAST (Wascana and Kelsey campuses) and the College of Nursing at U of S in support of a single program for RNs and RPNs, primarily a four-year, generalist, bachelor's degree program in nursing. Students who have completed three years of NEPS may receive a diploma and apply to register with RPNAS, though very few have done this to date.

The RPN program at SIAST Wascana had graduated about 60 students each year between 1993-97, three-quarters of these registered with the RPNAS following graduation. Only about one-third of RPN graduates were successful in securing full-time employment in psychiatric nursing; a total of about three-fourths found at least some part-time employment. Seats for nursing students in the province, funded by Learning (Post-Secondary Education and Skills Training), were being decreased in the mid-90s, and the 60 seats funded for RPN students at SIAST were rolled into the decreased total of 180 seats each year for entering nursing students at the NEPS in 1996. The number of nursing seats for students entering the NEPS program was increased to 260 in 1999.

The RPNAS has presented concerns about a lack of sufficient training in psychiatric nursing in the NEPS for several years. The RPN associations in Manitoba and Alberta appear to have expressed similar concerns and may request additional training before licensing NEPS graduates. In its conditional approval of NEPS in 1998, RPNAS identified revisions required for full approval. Following a site visit and assessment report by an external assessment team, the RPNAS (December, 2001) denied its approval of the NEPS in December 2001; the last class eligible to write the RPN registration exam is under negotiation.

While the external assessors (Crawford & Gabor, 2001) for the RPNAS recommended conditional approval for three years in their assessment report of the NEPS, the council of the RPNAS denied approval. It was the judgment of the external reviewers that the NEPS met three of the nine criteria of the RPNAS, "partially met" three criteria, and did not meet the remaining three criteria. The RPNAS agreed that the same three criteria were met, the same three criteria were not met, and determined that the three criteria judged to be "partially met" should be considered as not met. The findings of the RPNAS assessment of the NEPS are summarized as follows with respect to the nine criteria employed.

1. The curriculum **only partially meets** the content and skills required in the RPNAS standards and competencies.
2. There is **not** a minimum ratio of one RPN to seven RNs on the faculty.
3. Identifiable clinical psychiatric nursing training experiences are **not adequate**.
4. There are **not adequate** strategies in place to ensure socialization of students with the RPN profession.
5. The opportunities for RPN/RN faculty to interact and to promote and model professionalism are only **partially adequate**.
6. Mechanisms to ensure continuous program improvement and outcome evaluation are **adequate**.
7. There are **adequate** support services for faculty and students to ensure opportunities for student success.
8. Communication strategies to ensure that input and evaluation is sought from stakeholders are **adequate**.
9. Strategies to market the program are only **partially adequate**.

Between January 2000 and July 2002, 16 of the 18 NEPS graduates who have written the RPNAS licensing exam have passed. It appears that most, if not all, NEPS graduates who have registered with RPNAS and secured employment in the province have successfully completed probationary work periods with their employer. This may be taken as reasonable outcome evidence that NEPS graduates are considered competent to practice in the area of psychiatric/mental health nursing.

In the judgment of the RPNAS, however, the NEPS has not met some criteria established by the RPNAS. The distinction between the competency of the graduates and program criteria is an important one.

The NEPS program is discussed further below (the next section on RNs, education and training), including the training provided in mental health.

Opportunities for registered psychiatric nurses to pursue master's degree training are very limited. While the master's nursing program in the College of Nursing at U of S would allow students to choose to specialize in psychiatric/mental health nursing, this option should be promoted for registered psychiatric nurses in the province.

Issues

With practically no recent NEPS graduates registering with the RPNAS, the future of the profession of registered psychiatric nursing in the province is uncertain.

If there continue to be less than a handful of NEPS graduates registering as psychiatric nurses each year, then the number of RPNs will decrease by about 25 RPNs each year between 2000-2005, assuming that retention rates remain the same as in the past (using Elliott's, 1999, projections for the supply of registered nurses under a "status quo" scenario, applied to RPNs). If the number of RPNs leaving the profession increases, that is, if the retention rate decreases, which is a likely scenario given the uncertain future of the profession, then the number of RPNs in the province may decrease by about 33 RPNs each year over between 2000-2005 (Elliott's "worst case scenario", applied to RPNs). This would mean a decline of about 165 RPNS, or 16% of the workforce, by 2005. The supply of RPNs would decrease at a greater rate in the years after 2005, due to an increasing number of retirements.

If the RPN is to have a future as a mental health profession in the province, then one of two courses of action must be taken. Either changes need to be made in the NEPS and its working relationship with RPNAS so that a greater number of students and graduates are attracted to the RPN profession, or alternatively, other program arrangements for training RPNs need to be put in place. Each option is considered.

Prior to denying approval of the NEPS, RPNAS proposed to Government that the NEPS be revised to include a separate curriculum and degree for psychiatric nursing (RPNAS, January 24, 2001). It appears, however, that there were no discussions with NEPS about a separate program and/or degree for psychiatric nursing.

Alternatively, RPNAS proposed to Government that two other arrangements for training RPNs should be considered (RPNAS, January 24, 2001):

1) brokering the B.Sc. P.N. program offered at Brandon University through SIFC or Regional Colleges;

2) a modified return to previous nursing education programming in the province, with the first two years of a program taken by LPNs and registered nursing students (at SIAST) followed by two years for registered nursing students (at the U of S) leading to a BSN or a BScPN degree.

Such alternate degree programs for RPN training would require incremental funding for seats for RPN students; the RPNAS asserts the need for 60 seats, the number funded in 1997 prior to the NEPS. It appears that there was no further discussion with Government about these alternatives, nor with SIAST or the College of Nursing.

There is, unfortunately for the RPN profession, no uniform education and training programming across the four Western provinces: Brandon University offers a B.Sc.P.N; the NEPS awards a B.S.N; Grant MacEwan College, Edmonton, offers a two-year diploma program; in BC, Douglas College, Vancouver, offers an Advanced Diploma in Psychiatric Nursing, primarily via distance learning courses, and the Open University offers a degree program.

A range of options for education and training was considered at an invitational meeting of RPNAS members and guests in March 2002. Several options are considered as viable in the Conference Report (RPNAS, March 2002):

- renewed negotiations with NEPS for improvements in the program;
- a diploma RPN at SIAST, Wascana;
- a degree program located at SIAST in partnership with Brandon University.

Also considered viable as an option, but not preferred by RPNAS members, is the purchase of seats for psychiatric nursing at institutions outside the province in degree (Brandon University) and diploma programs (Grant MacEwan College, Douglas College).

The RPNAS and NEPS are, at the time of this writing, engaged in negotiations facilitated by Government. Such negotiations were recommended in a draft of this Final Report, April 2002. An agreement between NEPS and the RPNAS on revisions to the psychiatric/mental health training provided by NEPS is, in my view, desirable for the future of RPN as a profession in the province. Training in mental health/psychiatric nursing provided in NEPS is considered later in this Chapter (RNs, Education and Training).

If no arrangements for the training RPNs can be agreed to, then the RPN profession as we know it will wither, as few or no new nurses register with the RPNAS. This too is an option that must be considered. The RPN is a profession only in the four Western provinces. In the rest of the country, RNs are employed in psychiatric and mental health settings. There is some tacit support for this in Saskatchewan, within the SRNA and the NEPS: the generalist model for bachelor's training of nurses has considerable support within the nursing profession across Canada.

While it is evident that RNs, educated in degree or diploma programs with less training in mental health than is provided in NEPS, do pursue careers in mental health, it is uncertain whether sufficient numbers of RNs would be attracted to and be competent to replace the more than 1000 RPNs currently practicing in the province. Mental health is one of the least preferred areas of nursing practice in many places: only 5% of Canadian nurses are employed in psychiatric/mental health settings (see Appendix 4); in Australia nursing students regard mental health nursing as the least desirable of ten clinical specialties (Stephens & Dulhunty, 1994).

The profession of registered psychiatric nursing has more than 50 years of history in the province. The profession is also recognized in the UK, and in Australia and New Zealand though a generic nursing program for the education of all registered nurses (like NEPS) is apparently being advanced in both countries.

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 become a significant challenge in this province.

PSYCHOLOGISTS

A profile of psychologists in Saskatchewan is presented in Appendix 2, including summary information on supply, demographics, mental health services, working conditions, wages and salaries, and education and training programs. Some comparison data from other jurisdictions is presented. Issues with respect to supply, scope of practice, and education and training are discussed.

Supply. The number of registered psychologists per population in Saskatchewan has historically been reported as the lowest in Canada. In 2000, there were 13,663 people per registered psychologist in the province; there were more registered psychologists per population in Alberta--by a factor of eight, in Manitoba—by a factor of three, and across Canada—by a factor of five.

These numbers, however, do not provide an accurate picture. There are important differences across the country in Acts that register psychologists. In Saskatchewan since 1962, the Saskatchewan Psychological Association (SPA, the regulatory body) registered psychologists with a doctoral degree only. This is also the case in Manitoba, and currently in BC and Ontario; persons with a master's degree are registered as "psychological associates" with limitations on their independent practice in Manitoba and Ontario. In the remaining jurisdictions, including Alberta, the educational requirement for practice is a master's degree; in some of these jurisdictions the title "psychologist" is reserved for doctoral graduates. In Saskatchewan, then, a significant number are employed as psychologists with a master's degree but their numbers have not been included among registered psychologists in past years.

The ratio of registered psychologists per population has changed with the proclamation in March 2002 of the 1997 *Psychologists Act*. Persons with master's degrees in psychology are able to register as psychologists. The transitional council of the new College of Psychologists has approved 175 applicants, about another 80 applications are in process. Together with the current 80 SPA registered psychologists, it is expected that about 335 will be registered as psychologists in 2002.

The ratio of registered psychologists per population can be expected to be about 1/3053 in 2002 (compared to 1/13,663 under previous SPA registration regulations). Saskatchewan is unique in registering school psychologists whose numbers are estimated to be 70-100 in the new College. If these are excluded, for the purpose of comparing numbers of registered psychologists across jurisdictions where they are not included in workforce numbers, then the ratio of psychologists per population in the province will be 1/4000+ in 2002. Thus, the supply of psychologists in Saskatchewan is similar to that in Manitoba, about one-third of the supply of psychologists in Alberta, and about one-half the supply in Canada.

Location. Data on the location of psychologists employed in the health sector (section 2.1, Appendix 2) shows that there are about twice the number of psychologists per population in Saskatoon than in Regina and rural areas. The distribution is likely even more skewed toward greater representation of psychologists in Saskatoon than elsewhere, because most of the doctoral psychologists are located in Saskatoon and many are not counted in the Saskatchewan Health Employers Surveys; rather a number are in full-time private practice, or employed at the U of S (Departments of Psychology, Educational Psychology, Student Counseling) and do part-time private practice, or are employed in settings that appear not to have completed the Health Employers Survey (Regional Psychiatric Centre, Corrections Service of Canada).

Age. The average age, 45 for those employed in the health sector, is somewhat older than social workers and registered nurses, similar to the average age of LPNs and family physicians, and younger than psychiatrists.

Gender. Seventy-two percent of psychologists in the health sector are female, similar to the proportion of females in social work.

Employment and mental health services. The majority of psychologists work in the health sector: in health districts in mental health services (64.5 FTEs); in health districts in other areas; in corrections and other justice programs; in addictions; in post-secondary institutions, teaching or providing services in mental health; and in private practice. In addition, a significant number are employed as educational or school psychologists, providing mental health services in elementary and secondary schools.

Competencies and scope of practice. The scope of the practice of psychology is defined in legislation in five provinces; it is not defined in the 1997 Act. It is desirable that the practice of psychology be defined in legislation. The Saskatchewan Psychological Association, now subsumed in the College of Psychologists, endorsed the recent *Mutual Recognition Agreement of the Regulatory Bodies for Professional Psychologists in Canada,* which sets out well-defined core competencies in seven areas: interpersonal relations, assessment and evaluation, intervention and consultation, research, ethics and standards, and supervision. Knowledge areas and skills are also detailed in this document that will facilitate mobility of psychologists between provinces.

The discipline of psychology covers a broad range of specialties in the biological, cognitive, developmental and social study of human behaviour. Within the discipline, clinical psychology is the major practice area, and while many clinical psychologists are generalists, increasingly it is viewed in terms of practice specialties, such as child/adult/or geriatric clinical, clinical neuropsychology, educational/school, forensic, health, counseling, and industrial/organizational psychology. Specialized education and training, at master's, doctoral and postdoctoral levels, are increasingly offered in universities in Canada, and specialty associations in each area exist. Competencies in each specialty are established or being developed. Increasing specialization is expected, and is more advanced in the U.S., where post-doctoral training and licensing is required in some jurisdictions. In the U.S., psychologists with post-doctoral training are licensed to prescribe psychotropic medications in some jurisdictions. In Saskatchewan, psychologists registering with the College are required to state their specialty area of practice in terms of broad areas (clinical, school, counseling) and client groups (children and youth, adults), and provide evidence of training in the specialty; then registered psychologists are ethically required to practice within their specialty area.

Working conditions. Vacancy and turnover rates have been the highest for psychologists among mental health professionals, averaging over 10% in the health sector during the last decade and considerably higher for Doctoral psychologists according to reports from psychologists. Salaries for psychologists are the highest among mental health professionals (save for psychiatrists and family physicians).

A new collective bargaining agreement signed between SAHO and the Health Science Association which became effective November 3, 2003, includes an overall salary increase of 21% over 3.5 years. This goes a long way toward addressing retention and recruitment issues.

Hourly wages for psychologists in the province are now 9% -17% higher than those in Manitoba (under a contract that expired in 2001), except at the maximum wage for Doctoral psychologists which are slightly higher in Manitoba; wages are slightly lower at the Master's level and slightly higher at the Doctoral level than those in Alberta (under a contract which also expired in 2001); wages here are 2%-6% lower than in BC. Given Saskatchewan's lower costs of living, wages for psychologists now appear to be reasonably competitive with those in BC and Alberta; in recent past years, wages here have been significantly lower.

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.

Education and training. Post-graduate training, following a bachelor's degree in psychology, is required for practice. Graduate training is provided by the two Departments of Psychology, exclusively at the doctoral level at the U of S, and while the U of R has offered primarily a master's program it has proposed to offer exclusively a doctoral program. Graduate training is also provided at both universities in Education; in both Departments of Educational Psychology training in counseling and school psychology has been almost exclusively at the master's level; at the U of S, the Department of Educational Psychology and Special Education is planning a doctoral program in counseling psychology.

In recent years, there have been about six doctoral graduates trained in the province each year (5 of these in clinical psychology); about 25 master's graduates, 75% in educational/school psychology or counseling and 25% in clinical psychology. In recent years, and historically, about 50% of doctoral students trained in the province have entered practice here and remained in the province over the years. The majority of the 40 doctoral clinical psychologists trained at the U of S who have remained Saskatchewan following graduation are employed in clinical practice positions throughout tin Saskatoon; nine are presently in full-time private practice in Saskatoon.

Though follow up information on master's graduates in educational psychology is not available, many appear to have remained in the province. Increasingly, some are hired by employers in health/mental health because of their availability. There are concerns, however, that master's training in educational psychology is not adequate for the development of beginning competencies for practice in the mental health sector. Some master's graduates in educational psychology are providing private psychological services; without considerable additional training and supervision beyond their master's training they are not competent to practice independently in the mental health sector.

Doctoral programs in clinical psychology across Canada (20 are accredited by the Canadian and American Psychological Associations) require a one-year, full time predoctoral internship at an accredited program, typically in a teaching hospital. There is one accredited internship program in Saskatchewan at Royal University Hospital/SDH that trains two interns each year. All of these come from out of province for their internships, and half have remained after completing their training in recent years. Saskatchewan is disadvantaged in the number of training places in internships compared to other Western provinces.

Given the recognition of the cost-benefit of predoctoral internship training in clinical psychology, a task force has recently been initiated by mental health and community health managers to expand internship training. Three priorities have been established: developing a predoctoral internship in Regina; expanding internship training to rural areas modeled after a successful program in Manitoba; examining the viability of specialty post-doctoral training in Saskatoon.

Issues

Given that the supply of psychologists in the province is about one-half the average across Canada and the high vacancy and turnover rates, recruitment and retention remains a significant concern. A group of psychologists from a number of health districts is in the process of drafting a proposal for recruitment strategies; funding for increased predoctoral internships in the province is a priority and one short-term strategy is the use of fall-in money from unfilled vacancies for predoctoral intern positions. About half of the predoctoral interns trained in the province have taken positions here in recent years, and increasing the

number of predoctoral interns from the present two to perhaps ten per year is the preferred recruitment strategy.

Enhanced resources for the doctoral graduate programs in clinical psychology at U of S and U of R are also desirable as one-half of these graduates have also remained in the province. Enhanced resources to graduate training programs for master's school and counseling psychologists in the program planned for the Department of Educational Psychology and Special Education at the U of S is likewise a good investment for recruitment in the future.

The Department of Educational Psychology at the University of Regina should, in my view, review its master's program in terms of the quality of the program in preparing graduates for employment in mental health and for private practice.

The scope of practice of psychology should be defined in legislation. This is one way to monitor the quality of services provided by non-regulated counselors in private practice and enhance protection of the public.

The profession has now developed a beginning set of competencies for practice in its major specialty areas. A priority for the new College of Psychologists should be to carefully assess competencies at the entry level, and then monitor competencies of registered psychologists. Continuing education and training opportunities are also much needed in the profession; and, psychology should be a leader in offering continuing education opportunities for other mental health care providers.

Psychiatrists

A profile of psychiatrists in Saskatchewan is presented in Appendix 3, including summary information on supply, demographics, mental health services, and education and training programs. Some comparison data from other jurisdictions is presented. Issues with respect to recruitment and retention, fees and salaries, contract psychiatrists, and shared mental health care with family physicians are discussed.

Supply. The number of certified psychiatrists (45) per population in Saskatchewan (1 psychiatrist per 22,681 people) is among the very lowest in the country, only PEI and Yukon have fewer psychiatrists per capita. There is about one-third the number of certified psychiatrists per population in Saskatchewan than the average in Canada (1 per 7967) and Manitoba (1/8513), and about one-half the ratio of psychiatrists to population compared to Alberta (1/11,808).

Special licenses to practice psychiatry are granted by the Minister of Health to an additional 23 physicians who are not certified in psychiatry by the Royal College of Physicians and Surgeons, bringing the total to 68 physicians in Saskatchewan currently practicing psychiatry. Comparable data on non-certified psychiatrists from other jurisdictions are not available. The total number of psychiatrists in the province has decreased from 96 in 1992, a reduction of 28 psychiatrists, or 29%, in the past decade.

The decrease in the number of psychiatrists in Saskatchewan should be seen in the context of the decreasing number and proportion of physicians entering psychiatry in Canada and worldwide (Chandarana & Pellizzari, 2001). This trend cannot, however, account for the 29% reduction in the number of psychiatrists in the province over the last decade.

The recruitment and retention of more psychiatrists has been a challenge in Saskatchewan for several decades. The challenge remains. The recent report, Psychiatry Human Resource Plan, Province of Saskatchewan, 2001, the work of a committee of stakeholders organized by the

Regina and Saskatoon Health Districts, offers a number of recommendations. Among the recommendations given highest priority by the stakeholders are the following:

- establishment of a Provincial Psychiatry Human Resource Planning and Implementation Committee;
- creation of enhanced professional incentives (e.g., affiliation with the College of Medicine at U of S);
- creation of compensations methods that promote flexibility in practice arrangements (e.g., alternate payment, blended alternate and fee-for-service payment, salaried);
- removal of barriers to utilizing provincial resources created by maintaining separate physician compensation pools (e.g., separating fee-for-service funding from district funding);
- funding by Health for a target of 96 psychiatrists regardless of compensation method;
- not permitting health districts with vacancies in psychiatry to retain funding unless the service is being provided through an acceptable alternative arrangement, and putting unused funding into recruitment and retention initiatives;
- development of a system of graduated certification for foreign trained non certified psychiatrists practicing on contracts;
- increase the number of residency training positions in psychiatry at the College of Medicine;
- increase opportunities for resident psychiatrists to receive a portion of their training outside of Saskatoon in rural areas;
- increase the capacity to recruit experienced psychiatrists from outside the province;
- increase accessibility to specialized psychiatry services in forensic, geriatric and child and youth areas;
- enhancement of the quality of the work environment for psychiatrists (e.g., adequately resourced multidisciplinary mental health teams, permitting self-employment (private practice) as part of contracts with non certified psychiatrists; enhancing the professional autonomy and control given psychiatrists by employers).

Implementation of these recommendations would clearly constitute a significant step forward in meeting the challenges of recruitment and retention of psychiatrists.

Location. Approximately two-thirds of psychiatrists practice in Saskatoon and Regina, the majority in Saskatoon. The remaining one-third practice in rural locations, the large majority of these are not certified and practice on contracts with health districts. There are relatively fewer psychiatrists practicing in rural areas, where the ratio of psychiatrists to population is approximately 1/25,930, compared to 1/9,761 in Regina and Saskatoon.

Age. Psychiatrists in Canada are older, on average, than most other physicians; the average age of family physicians, in contrast, is younger than most other specialists. From the age distribution of certified psychiatrists (represented in Appendix 3 by years since M.D. graduation as a reasonable estimate), Saskatchewan psychiatrists are similar in age to their colleagues across the country, though somewhat older on average than psychiatrists in Manitoba and Alberta.

Psychiatrists on average are significantly older than all other mental health professionals, in the province and across Canada. Almost one-half of psychiatrists in the province are over age 50, 27% are over age 60. Many will be reducing or ceasing their practices in the next decade.

Gender. About one-third of certified psychiatrists in the province are female, which is comparable to the Canadian proportion and somewhat greater than the proportion of female psychiatrists in both Manitoba and Alberta.

Practice settings. About half of the psychiatrists are practicing in private offices, all are certified. The other half practice on contract or in the employ of health districts and boards, two-thirds (or 23) of these are not certified.

Mental Health Services by Diagnosis. What kinds of mental health patients are seen by physicians? The psychiatric diagnosis of patients (outpatients and inpatients) seen by physicians, both psychiatrists and family physicians, in 1999-2000 is reported in section 2.2 of Appendix 3.

Of the physician services for mental health reason in the province, the large majority of which are outpatient services, psychiatrists provide 32%; family physicians provide 68%. Patients diagnosed with mood disorders (including depressive disorders and affective psychoses) and anxiety disorders constitute more than one-half of the mental health outpatients seen by physicians (34.3% and 23%, respectively). Other diagnostic groupings represented among outpatients seen by physicians include schizophrenia (4.8%), dementias (2.2%), alcohol and drug disorders (7.9%), adjustment and stress disorders (5.1%), and infancy, childhood and adolescent disorders (7.3%). Certified psychiatrists, it can be assumed, see the more serious and complicated of these outpatients.

The large majority of inpatients treated in the nine mental health units in the province are seen by non-certified psychiatrists. There are, on average each day, 204 inpatients being treated in these mental health units (another 33 inpatients, on average each day, are treated in other hospital units across the province). Mental health inpatients who suffer from depressive and other mood disorders constitute 39% of all patients treated in these units, 24 % are schizophrenic patients.

In addition, psychiatrists treat inpatients at the Saskatchewan Hospital North Battleford, at which there are a daily average of 161 patients. About 87% (140) of these patients are long-term patients who are chronically mentally ill, suffering from schizophrenia, affective psychoses, and dementias and other senile organic psychotic conditions. The remaining 13% (21) patients at SHNB are forensic patients who suffer from serious mental disorders and are remanded for assessment, treatment and special disposition under the Criminal Code for persons found “not criminally responsible.”

Not included among inpatients are those mentally ill patients who reside in group homes, apartments, and approved homes across the province, for which there were 1157 beds in 1999-2000. The large majority of these patients have serious mental disorders; all require the services of psychiatrists.

Fees and salaries. Most certified psychiatrists practice on a fee-for-service basis. The fees for services provided by psychiatrists are the lowest among the fees for medical specialists. A recent increase of about 14% in fees for psychiatric services was clearly desirable.

All non-certified psychiatrists practice on contract with health districts. In 2000 the tax court ruled that such psychiatry contracts were ones that defined an employer-employee relationship, that is, that contract psychiatrists were not considered to be self-employed for tax purposes. This, in effect, substantially reduces the after tax income of contract psychiatrists. Negotiations are ongoing between individual psychiatrists and health districts to resolve differences over payment of past taxes owing by these psychiatrists. Also, negotiations continue between medical

associations, including the SMA, and the Canada Customs and Revenue Agency, in review of the tax court ruling. Of ongoing concern to contract psychiatrists is the fact that most contracts do not permit self-employed, i.e., private practice. As noted earlier (supply of psychiatrists), the Psychiatry Human Resource Plan recommends that contracts permit self-employment.

Education and training. The residency-training program in psychiatry, College of Medicine, U of S, admits three residents each year into its five-year training program. There are, then, a total of about 15 residents in training each year. The first year of residency training is in general medicine and is completed in Regina; the remaining four years are completed in Saskatoon in psychiatry. Attracting medical graduates into psychiatry remains a challenge in Canada. Last year, only 5% of Canadian medical graduates ranked psychiatry as their first choice, and 14 % of the psychiatry residency positions across the country remained vacant (Chandarana and Pellizzari, 2001).

There are about 11 faculties in the Department of psychiatry who provide training, along with 22 part-time psychiatrists in the community. Faculty and other resources are adequate to meet the training requirements of the 15 residents. The program could not train a greater number of residents without additional resources.

In a recent internal survey of the program, the program was judged to provide residents with ample training in the biological aspects of psychiatric care, long-term psychiatric care, community psychiatry, forensic psychiatry, and psychotherapy in general, except for cognitive behavioural therapy, an important therapy approach effective in treating a range of mental health disorders and problems. The program does not provide adequate training in the areas of functional neuro-anatomy, neuro-radiology, emergency mental health services, rural and aboriginal mental health, consultation and liaison, or in shared mental health with family medicine; residents have not been very productive in research publications.

Issues

Recruitment and retention. The shortage of psychiatrists in the province has been a historic challenge. The shortage of psychiatrists remains a critical concern. Recruitment and retention of psychiatrists must remain a high priority for Saskatchewan Health and for regional health authorities.

The critical issues that need to be addressed in recruiting and retaining psychiatrists have all been addressed in the recent Psychiatry Human Resource Plan 2001. The recommendations offered, as highlighted above, should be implemented. It is especially important that Districts/Authorities retain funding allocated for psychiatrists until positions are filled.

An increase in bursaries for residents in psychiatry, and other medical specialties, has recently been implemented.

Shared mental health care. The need to improve working relationships between psychiatry and family medicine has been recognized for some time. In 1996, the College of Family Physicians of Canada and the Canadian Psychiatric Association released their conjoint position on shared mental health care, which includes a number of general recommendations for closer collaboration in meeting the mental health needs of the many patients seen by family physicians. There appears to be little, if any, progress in the province toward better meeting the challenges of shared mental health care. The major challenges are summarized as follows.

- Problems that have been identified include a lack of communication between psychiatrists and family physicians caring for the same individual, difficulty on the part of family physicians in accessing consultation and treatment services for their patients, and a lack of mutual respect and support for the contributions that providers from different disciplines can make in delivering mental health care. There are three general problems to be addressed: difficulty with access, poor communication and lack of personal contact.

- Alternative models of collaboration that are more collegial and interactive, with clearly defined roles and responsibilities for both family physician and psychiatrist, are required to promote an integrated and holistic approach to physical and mental health problems and ensure greater continuity of care. This can be achieved if the psychiatrist and family physician work collaboratively to share the delivery of mental health care.

- Shared care is a process of collaboration between the family physician and the psychiatrist that enables the responsibilities of care to be apportioned according to the treatment needs of the patient at different points in time in the course of a mental health problem and the respective skills of the family physician and psychiatrist. Rather than being seen as a separate style of practice, shared care can become a valuable extension of the clinical practice of psychiatrists and family physicians and an integral part of the treatment of any individual with a mental disorder whenever a family physician requires additional input from a psychiatrist or psychiatric service.

- Three different but complementary strategies can be employed to support and enhance shared mental health care. The goals of these strategies are 1) to improve communication in the working relationship between a psychiatrist or psychiatric service and local family physicians, 2) to establish liaison relationships between psychiatrists or psychiatric services and one or more local family physicians, 3) to bring psychiatrists and/or other mental health providers into the family physician's office.

REGISTERED NURSES

A profile of RNs in Saskatchewan is presented in Appendix 4, including summary information on supply, demographics, mental health services, working conditions, wages, and education and training programs. Some comparison data from other jurisdictions is presented. Issues with respect to mental health care, working conditions, and education and training are discussed.

Supply. The number of RNs per population, as reported by CIHI, 2000, is greater than in Alberta and Canada, and somewhat less than in Manitoba. The number of RNs has increased slightly from 1997-2000, an increase of about 2 percent. Numbers reported by the SRNA (2001) differ from CIHI's report and show a recent decrease in the number of employed RNs, from about 9170 in 1997 to 8995 in 2000, and a decrease of 10% between 1990-2000. Elliott (1999) concluded that employment of RNs remained relatively constant between 1989-1999. A further decrease of about 3% in the number of employed RNs in 2001 in the province has been reported by SRNA and SUN.

Location. About one-third of FTE RNs employed in the health sector are located in rural Saskatchewan (i.e., all locations outside of Regina and Saskatoon), two-thirds are employed in Regina and Saskatoon. There are only about one-half FTE RNs employed per population in rural areas compared to in Regina and Saskatoon.

Age. The average age of RNs is 43.6 years, which is very similar to the average age of nurses in Manitoba, Alberta and Canada. On average, RNs are somewhat older than RPNs and significantly younger than LPNs in the province.

Gender. Over 97 percent of RNs are female. This is identical to the proportion of LPNs who are female; 16 percent of RPNs are male.

Employment settings and areas of practice. One-half of the RNs in the province are employed full-time; half are employed on a part-time or casual basis. This appears to be similar to employment status in other jurisdictions, though a greater proportion of Saskatchewan RNs appears to work for more than one employer.

Almost 60 percent of RNs are employed in hospitals, somewhat less than in other jurisdictions. A greater proportion of RNs in the province are employed in community health (health centres and home care), 17%, compared to RNs in other jurisdictions (12% in Canada, 9% in Manitoba).

Eighty-nine percent of RNs work in direct patient care areas, with the greatest numbers in medical/surgical (18%), geriatric (14%), home care (7%), critical care (8%), and community health (7%). Only 2 percent of RNs are employed in psychiatric/mental health care. An average of 5 percent of RNs in Canada are employed in psychiatric/mental health care, many more than in the province, a difference which is due in significant part to the presence of RPNs here. There are only about 67.5 FTE RNs employed in primary care nursing in the province, which represents 1.4% of the RNs in the health sector.

Mental health services provided by RNs. 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, about 14% of the total hospital days for mental health reasons in the province are in general hospital units (Saskatchewan Health, Community Care Branch, 2001), mostly in rural areas and 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. Psychological and social factors do indeed play a role in the treatment and care of medical patients seen by RNs in medical/surgical, critical care, maternal, and pediatric settings, and in primary care.

Working conditions. Vacancy rates for RN positions in the health sector have increased significantly in the past few years; in 2000 the overall vacancy rate was 4.4%, compared with a 1-2% vacancy rate in the preceding decade. The turnover rate is also quite high—5.9% in rural areas and 3.9% in Saskatoon and Regina in 2000. Vacancy and turnover rates for RNs are similar to rates for RPNs and somewhat higher than rates for LPNs in Saskatchewan. The vacancy rate for primary care nurses is very high, 19% in rural Saskatchewan in 2000.

The collective bargaining agreement signed between SAHO and SUN in April, 2002, gives nurses at the minimum wage level an increase of about 20% over the three years of the contract. This goes some way toward addressing recruitment and retention issues for nurses.

Comparisons with the other three provinces in Western Canada, presented in Appendix 1 (section 3), show that hourly wages for nurses in Saskatchewan are now about 5% higher than those in Manitoba, and lower than those in both Alberta and BC (7% lower at the minimum wage level, 17% lower at the maximum wage level). Given the lower costs of living in Saskatchewan, wages for nurses here seem to

be reasonably competitive with Alberta and BC at the minimum wage level though not at the maximum level. However, new contract negotiations are underway in Alberta which will provide for increased wages effective April, 2003.

The SRNA (2001) reports total outmigration of about 350 RNs each year over recent years, over one-half leave the province for Alberta; net outmigration of SRNA membership has averaged 225 (about 2%) from 1997-2000.

Dissatisfaction with the workplace and working conditions has been reported by the SRNA and SUN in recent years. Each week a reported 8.5% of the nursing workforce is absent due to illness. Nurses experience high levels of workplace stress due to increased patient acuity, higher nurse/patient ratios, chronic overtime and lack of job security, and a lack of recognition and support. Elliott (1999) found that while the incidence of paid overtime in Saskatchewan hospitals (among all staff) has been growing slowly but steadily since 1992 it has remained below the level it was in 1990.

Concerns with respect to working conditions of nurses and others employed in the health and mental health sectors in the province were thoroughly reviewed in a recent report (Backman, 2000). These concerns and recommendations to address them are considered in Chapter 5.

Education and training. The number of nursing graduates from Saskatchewan post-secondary institutions has declined significantly since the peak near 450 (diploma and degree graduates) in 1992-93 (Elliott, 1999). Similar decreases in nursing graduates were experienced across Canada; nursing graduates decreased by over 50 percent in Canada in the 1990s. The number of degree graduates was relatively constant at about 60 until 2000 when the initial class of 98 graduated with degrees from the NEPS; 162 degree nursing students graduated in 2001, and the number should approach 260 this year and thereafter. With the initiation of NEPS in 1996, the number of diploma graduates has decreased to nearly zero; in 1991-92, there were 387 diploma graduates from SIAST. Saskatchewan Post-Secondary Education and Skills Training currently provides funding for 260 seats in NEPS. The SRNA asserts that at least 400 seats are needed to address a shortage of registered nurses. There is no shortage of applicants to the NEPS; in 2001, 750 applied and 271 were accepted into the program; in 2002, 260 were accepted from a total of 854 applicants to NEPS.

The NEPS has been reviewed in the past year by the U of S (its Systematic Program Review process), and by the SRNA and the RPNAS for approval. The NEPS is recognized in nursing as an innovative program with a unique focus on training nurses in primary health care. Both the U of S and the SRNA have assessed the program as one of good quality that serves the needs of the province well.

The RPNAS denied approval of NEPS for reasons discussed earlier. The two most critical deficiencies in NEPS with respect to education and training in mental health are, in my judgment: 1) the curriculum only partially meets the content and skills required in the RPNAS standards and competencies; and 2) identifiable clinical psychiatric nursing training experiences are not adequate. After reviewing the curriculum and the clinical practicum training experiences and discussions with NEPS faculty and graduates, it is my assessment that a good deal of training in mental health is available in the program.

- It appears that NEPS provides more training in mental health than most if not all of the nursing programs in Canada.
- The curriculum was explicitly developed to incorporate most or all of the content of the previous SIAST program in psychiatric nursing.
- All students are required to complete one clinical practicum in an acute mental health setting (NURS 233.6, 140 hours). For students interested in a career in mental health, it is possible for them to complete additional clinical practicums in appropriate settings in NURS 324.3 (children

and adolescents, 66 hours), NURS 420.3 (community mental health, 104 hours), and senior practicums, NURS 422.3, 423.3, 425.6 (450 hours in total). In addition, short clinical experiences are included as a part of some other courses in the 2nd and 3rd years. All clinical practicums are supervised by nursing faculty on site.

- NEPS faculty include about 7 RPNs at Wascana and Kelsey campuses, and four faculty in the College of Nursing with Master's or Doctoral degrees whose teaching, research and practice expertise is in mental health.
- Students and recent graduates who are interested in psychiatric nursing emphasize that mental health is presented throughout the program as integral to health, and they point out that more NEPS students are interested in careers in mental health than are represented by the few graduates that have registered in RPNAS.

The training in mental health provided in NEPS may be enhanced by attention to some of the recommendations offered by Crawford and Gabor (2001) under RPNAS criteria 1 and 3. In particular, the availability and quality of clinical practicum training in identifiable psychiatric/mental health settings should be improved. A student portfolio to document in greater detail individual students' clinical learning experiences in mental health is desirable; ideally it should include benchmarks for competencies as well as the essential evidence used in assessing each benchmark (e.g., observed practice, assessment by supervisors, documentation of learning accomplishments in courses and practicums) (see the "Exit Profile" developed by the Northern (UK) Centre for Mental Health (2000) as an example of the documentation of beginning competencies for mental health practice in nursing).

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

The Native Access Program to Nursing, where three Aboriginal counselors provide support to over 60 nursing students, has resulted in NEPS having the largest number of Aboriginal nursing students in Canada. Also, an initiative to offer college-level courses to 20 Aboriginal students interested in careers in nursing and health care was offered for the first time in 2001-02 at Prince Albert. Most of the students who completed this training have been accepted into the NEPS. These programs are certainly wise investments.

The College of Nursing offers a post registration BSN program, as a distance program, for diploma nurses who wish to complete a degree. It meets an important need. A number of RPNs have completed the program in recent years. As recommended in the Systematic Program Review completed by U of S, increasing the number of spaces, improving communication between students and instructors, implementing a system of Prior Learning Assessment and Recognition, and enhancing continuing education programming are all desirable improvements.

The College of Nursing also offers a Master's program with about 5-8 graduates annually. Most graduates pursue careers in teaching or administration, with only an estimated 10% practicing as clinical nurse specialists after a Masters degree. Given the desire to enhance primary care services in the province, clinical nurse specialists and others who have expertise in primary care are needed in greater numbers. Master's nursing students may choose to specialize in psychiatric/mental health nursing, and this option should be promoted for registered psychiatric nurses in the province.

A number of advanced education programs in nursing are offered by the Nursing Division, SIAST: nursing re-entry, primary care nurse practitioner, geriatric assessment for RNs/RPNs. As nursing becomes more specialized, these and other such programs are especially valuable. An advanced certificate in mental health should be considered.

SIAST, Science and Health Division, will begin offering a program in caring for Dementia patients for health workers later in 2002. Though this is intended for nursing assistants/aides, short courses such as this are needed in mental health for continuing education for a range of mental health professionals and workers. This is further discussed at the end of the chapter, Key Issues.

Issues

The main issue for nursing with respect to mental health care is the enhancement of education and training experiences, in NEPS and advanced and continuing education, and hence improving the competencies of RNs and RPNs in mental health.

Mental health care has a significant place in nursing beyond care in psychiatric hospital units. The place of mental health care will become more central as services in community health, home care, geriatric care, forensic care, and especially primary health care continue to expand.

LICENSED PRACTICAL NURSES

A profile of LPNs in Saskatchewan is presented in Appendix 5, including summary information on supply, demographics, mental health services, working conditions, wages, and education and training programs. Some comparison data from other jurisdictions is presented. Issues with respect to mental health care, working conditions, and education and training are discussed in this section.

Supply. The number of LPNs declined steadily between 1990-1998, by about 20%. In the past three years the number of LPNs has increased slightly. The number of seats for LPN students has been increased from 40 in 1998 to 84 this year. The current ratio of LPNs to the population in Saskatchewan is higher than in Alberta.

Location. Sixty percent of LPNs are employed in rural areas, 40% in Regina and Saskatoon. LPNs are the exception to the rule that the health workforce is under represented in rural compared to urban Saskatchewan. This must be seen in the context that fewer LPNs than RNs are employed full-time (43.6% vs. 51%); even fewer LPNs are employed full-time in rural areas. Also, while it is the case that there are relatively more LPNs working in rural areas than urban, there are also many fewer RNs in rural compared to urban areas.

Age. The age distribution of LPNs is significantly more skewed toward the older ages than the distribution for RNs and RPNs. Thus, the proportion of LPNs who will retire over the next decade is greater than for RNs and RPNs.

Gender. Over 97 percent of LPNs are female. This is identical to the proportion of RNs who are female; 16 percent of RPNs are male.

Employment and areas of practice. Less than one-half of LPNs are employed full-time; 56.4% are employed on a part-time or casual basis; in rural areas, compared to the two large urban centres, a greater proportion of LPNs are employed on a part-time or casual basis.

Fifty-eight percent of LPNs work in acute care settings, 11% in nursing homes. There are very few LPNs employed in mental health-by-health districts in the province, a total of 34.6 FTEs. Less than one percent of LPNs are employed in psychiatric hospitals, 2% in community care.

Mental health services provided by LPNs. The numbers just reported, however, do not tell the whole story of LPNs in the mental health sector. Mentally disorder patients are commonly cared for by LPNs who practice in geriatric care (16.4%) where as many as one-half may suffer from dementias and/or depression, and in rural hospitals (21%) where some psychiatric patients are cared for (2077 psychiatric patients separated from non-psychiatric units in hospitals in Saskatchewan; 94% of these patients were in health districts without inpatient mental health units; the average length of stay for these psychiatric patients was 6 days (see Appendix 3, section 2.2)). At least 40% of LPNs may be seen as providing a significant amount of mental health care.

Competencies and scope of practice. Are the competencies of LPNs, their knowledge and skills, adequate to support practice in mental health care? What kind of care? These are important questions, though difficult to answer with clarity and in sufficient detail to be useful.

On the one hand, with a 14-month certificate training program that provides relatively little specific knowledge and skill training in mental health care, most professionals and managers in mental health do not see LPNs as able to provide mental health care independently. The scope of practice approved by the SALPN supports this view: "As the acuity or complexity of care increases and/or outcomes are not predictable and an advanced level of knowledge is required, the Licensed Practical Nurse works in partnership with other health care professionals as an interdependent member of the team to meet the care needs of the client(s)."

On the other hand, the beginning competencies identified for LPNs include knowledge about: communications, therapeutic relationship and caring; groups and group dynamics, the nature of human needs; growth and development; community health nursing concepts; and mental health nursing concepts. Further, personal competencies (interpersonal skills and caring) are central to the quality of the mental health services provided by all professionals, necessary though not sufficient. LPNs with these professional and personal competencies, in partnership with other mental health professionals, can provide valuable mental health care. This is particularly the case in geriatric, home care, extended care, and inpatient care of mentally disordered.

The 1997 federal Nursing Competencies project found that the competencies of LPNs overlap with 50-70 percent of those of RNs; LPNs in some jurisdictions including Saskatchewan administer medications, initiate intravenous therapy, and perform roles in the operating room.

Working conditions. Vacancy rates for LPN positions in the health sector have increased significantly in the past few years; in 2000 the overall vacancy rate was 3%, compared with a 1% vacancy rate in the preceding decade. The turnover rate is also quite high—3.9% in 2000. Vacancy and turnover rates for LPNs are somewhat lower than rates for RNs and RPNs in Saskatchewan, and lower in rural than urban areas.

Wages for LPNs in the province are reasonably comparable to those in Manitoba and Alberta at the minimum rate; at the maximum hourly rate, however, wages are significantly higher in Manitoba (22% higher) and in Alberta (12% higher). LPNs in BC are paid 40%-45% higher hourly wages compared to Saskatchewan LPNs. Wages for LPNs who are at the maximum pay level are not competitive with those in the three other Western provinces.

In the last two years, an increased proportion of graduates from the Practical Nursing Program have left the province for work elsewhere, over 20% each year, significantly more than the average of about 5% in recent previous years. Most moved to Alberta, to positions that permitted a broader scope of practice according to anecdotal reports.

Similar to the SRNA, the SALPN has reported that their members have been experiencing high levels of workplace stress and poor morale. Some of this is due to acute tensions between SALPN and SRNA in recent years over scope of practice. With *The Licensed Practical Nurses Act*, 2000, LPNs are no longer required to practice under the direction of a registered nurse. Still, it is the view of LPNs that they are not working to the full scope of their practice in the province in comparison to working conditions in the other three Western provinces.

Concerns with respect to working conditions of nurses and others employed in the health and mental health sectors in the province were thoroughly reviewed in a recent report (Backman, 2000). These concerns and recommendations to address them are considered in Chapter 5.

Education and training programs. The Practical Nursing Program is offered through SIAST, Nursing Division, at the Wascana (Regina) campus and the Woodland campus (Prince Albert), and in partnership with Regional Colleges and the Dumont Technical Institute (in Swift Current, Prince Albert, North Battleford, Watrous, Tisdale, Yorkton, Meadow Lake, LaRonge, and Estevan). There are 56 funded seats at the Wascana campus site, 16 at Woodland, and about 100 places through partnerships with Regional Colleges and Dumont Technical Institute sites across the province; these are numbers for the full 18 months of time to complete the program, annual numbers of students enrolled are lower. The number of seats funded by the Department of Learning has increased very significantly in recent years as shown in Appendix 5, section 4.1.

The program was extensively revised in recent years. Prior to the establishment of the NEPS, practical nursing students shared a common core curriculum for the first eight months with diploma nurses and psychiatric nurses in training at what was then the Wascana Institute. The present curriculum, expanded from 11 to 14 months in 2000 (with a 4 month break in the summer), is centered around primary health care, and includes clinical focuses and practicums in three areas: the well senior citizen, chronically ill including the mentally ill and acute care. The program is well regarded by LPNs.

With the expansion of the delivery of the SIAST, Nursing Division's Practical Nursing Program to Regional Colleges and Dumont Technical Institute sites, there is an increased number of students of Aboriginal heritage in training (e.g., in Prince Albert, Meadow Lake, and La Ronge).

SIAST, Nursing Division, Wascana campus, offers a practical nursing distance re-entry program to about 20 LPNs who have been out of the workforce for a time. Advanced Certificate programs are an effective way to upgrade the competencies of LPNs in targeted areas where there is a demand. Such programs might well be offered in mental health care, either in more general skills in caring for the mentally ill, or in more focused areas such as children and youth, forensic, addictions, rehabilitation, and intellectually disabled.

Issues

The two main issues with respect to LPNs in the mental health sector are their relative lack of training and competencies in mental health, and the extent to which LPNs could work to the full scope of their practical nursing competencies in long term care facilities and thus free-up greater time for RPNs and RNs to engage in mental health care.

Given that about 40 percent of LPNs today are estimated to be providing a significant amount of care to mentally ill patients, a case can be made for enhanced training and competencies in mental health. Advanced certificate programs may be a preferred option. If the competencies of LPNs in mental health care can be enhanced, then they can and should be utilized to a great extent in mental health settings, especially inpatient, residential and rehabilitation facilities for mentally disordered, intellectually handicapped, geriatric patients.

FAMILY PHYSICIANS

A profile of family physicians (general practitioners and family medicine specialists) in Saskatchewan is presented in Appendix 6, including summary information on supply, demographics, mental health services, working conditions, fees, and education and training programs. Some comparison data from other jurisdictions is presented. Issues with respect to recruitment and retention, the quality of mental health services provided by family physicians, shared mental health care by family physicians and psychiatrists, fee-for-service payment for mental health services, and education and training in mental health are discussed.

Supply. The number of family physicians per population in Saskatchewan (91 Family Physicians per 100,000 population) is slightly less than the Canadian average, very nearly the same as in Manitoba and somewhat greater than in Alberta. The ratio of family physicians to the population in the province has increased by about 6 percent in the past five years, from 86 per 100,000 in 1996, a rate of increase that is considerably higher than the average increase in Canada (0.3%) during the past five years.

The College of Family Physicians of Canada (2001), in releasing initial data from its National Family Physician Workforce Study, estimates that Canada currently requires at least 3,000 additional family doctors, and it notes that the situation is deteriorating with the country now producing fewer family physicians than a decade ago. They estimate that as much as 30 per cent of the population is currently having difficulty accessing a family doctor. Most family doctor's practices are full, and about two-thirds of all family physicians in the country report that they are no longer routinely accepting new patients; 7 percent are unequivocal in stating that they accept no new patients into their practices, with 2 percent of family physicians in Saskatchewan stating that they do not accept any new patients.

The proportion of general practitioners in the province who are foreign trained is 60 percent, almost three times greater than the national average (22%).

Location. There are relatively fewer family physicians practicing in rural Saskatchewan (70 Family Physicians per 100,000 population) than in Regina and Saskatoon (where there are 110 Family Physicians per 100,000 population). The ratio of family physicians to population in several small urban centres (Prince Albert, Moose Jaw, Swift Current) across the province approach that in Regina and Saskatoon; the number of family physicians per population is the greatest in Lloydminster (260/100,000), and the lowest in Greenland, Rolling Hills and Twin Rivers health districts (each at 50/100,000).

Age. The average age of family physicians in Saskatchewan (47.4) is about two years greater than in both Manitoba and Alberta; thirty percent are age 55 and older. Fifteen percent have been practicing more than 35 years since receiving their M.D., compared to an average of 9% nationally, and will be reducing or ceasing their practices in the coming decade.

Gender. There are relatively fewer females practicing family medicine in the province (25%) than there are in Canadian (34%), or in Manitoba (29%) and Alberta (34%).

Mental Health Services. Though difficult to document with precision, the data presented in Appendix 6 show that the large majority of family practitioners in Saskatchewan report that they provide mental health services, including psychotherapy and counseling. Family physicians provide a far greater proportion of physician services for mental health reason than do psychiatrists (i.e., 68% of the services in the province, 80% of the mental health services by physicians in rural Saskatchewan).

In 1999-00, it was estimated that 109,516 discrete individuals received over 500,000 mental health services from their family physician in the province (Saskatchewan Health, Community Care Branch, 2001). While data from the Medical Services and Health Registration Branch, Saskatchewan Health, suggests that about 5% of billings by family physicians are for mental health reason, this substantially underestimates mental health services provided by family physicians as the large majority of mental health services, such as prescriptions for psychotropic drugs, are billed under office visits (5B) and not included in these 5% of billings.

It is estimated that about one-third of family practice patients in Canada have identifiable mental health problems, and 25% of all patients who visit their family physician will have a diagnosable mental disorder (National Conjoint Committee on Mental Health Care, College of Family Physicians of Canada and the Canadian Psychiatric Association, 1996). These figures are likely higher for teenagers and the elderly. In research done in the U.S., it has been found that as many as 60% all patients who present to their family physicians have no demonstrable physical disease (Cummings & VandenBos, 1981; Saskatchewan Psychological Association, 2001)

It is clear that family physicians spend a large proportion of their time diagnosing and treating individuals who have emotional or mental health problems. The family physician is the first and often the only contact with a mental health care provider for individuals with mental health problems or disorders. These problems are often enduring, and many are severe and disabling. In addition, in parts of rural Saskatchewan, family physicians also treat individuals with mental disorders as hospital inpatients.

In a number of studies cited by the National Conjoint Committee on Mental Health Care (1996), family physicians emphasize the broad range of mental health problems they see, the high prevalence of these problems, the frequent overlap of physical and emotional symptoms, and the importance of the family physician as a key provider of mental health care. Family physicians indicate they deal with a large number of mental health problems in individuals of all ages, including many with serious mental illnesses, and they have stressed the importance of and need for a well-integrated biopsychosocial approach to all aspects of a patient's care.

Given the emphasis on enhancing primary care in the province (Saskatchewan Health, Health Action Plan, 2001), the role of family physicians and nurses in the assessment and treatment of mental illness is critical.

Are family physicians offering quality mental health services to their many patients who require them? There is practically no research that addresses this important question. The Health Services Utilization and Research Commission is currently planning a relevant research project. It is much needed, and such research should be a priority for the new Quality Council in the province. There are a number of reasons for concern about the quality of mental health services provided by family physicians:

- education and training in medicine and family medicine does not provide sufficient learning in mental health assessment and treatment;
- foreign trained family physicians often have had little or no training in psychiatry or mental health; the College of Physicians and Surgeons of Saskatchewan is currently planning to require training in psychiatry for family physicians educated in South Africa;

- access to and consultation with psychiatrists is very limited in the province and was addressed earlier in the section on psychiatrists;
- continuing education opportunities in mental health for family physicians is very limited;
- fee-for-service billing rewards volume and not time consuming mental health service; both the structure of the system and the amount of fees permitted, presents a significant disincentive to family physicians to provide the (time-intensive) assessment and counseling required for many patients with mental health problems;
- other mental health specialists such as RPNs and psychologists are not employed or otherwise made use of in most family practice settings in the province (an exception are the Community Clinics such the one in Saskatoon);
- there are concerns in mental health professions about family physicians providing assessments (e.g., the MMPI, a widely used psychodiagnostic assessment instrument) and informal advice rather than evidence-based treatments (e.g., cognitive behaviour therapy) for which they simply do not have training, expertise, or time.

There are 5-10 family physicians in the province that devote their practices exclusively to counseling and psychotherapy. They typically pursue continuing education and training to build and maintain their competencies, much of which is not credited as continuing education by the College of Family Physicians of Canada.

While most people have an enduring relationship with a single family physician, they do not always consider seeking mental health care from their family physician. A number of studies, including a Edmonton Household Survey, found that only 50% of individuals who were depressed would raise this with their family physician, and less than 10% of individuals with an addiction problem would talk about the problem unless specifically asked (Bland, 1993). This reluctance, and the stigma that remains attached to mental health problems in our society, present additional challenges to the family physician in providing mental health services.

Working Conditions. The recent survey results released by the College of Family Physicians of Canada that are summarized in Appendix 6, section 3, raise real concerns about the working conditions of family physicians currently practicing in the province. The sample surveyed, which represents 49% of family physicians in Saskatchewan, reported working 84 hours per week, significantly greater than the Canadian average though comparable to family physicians in Manitoba and Alberta. Of greatest concern is that 35% of Saskatchewan family physicians are planning one or more changes that would remove them from family practice in the province. This is the highest proportion of "planned departure" from practice reported in the country, nearly twice the Canadian rate. Concerns are reinforced by the fact that the net outmigration of family physicians from Saskatchewan is among the very highest in Canada.

The challenges of recruiting and retaining family physicians, especially in rural Saskatchewan, are well known, and though they beyond the scope of this report, it must be emphasized that the quality of mental health services in the province depends, critically, on an adequate supply of family physicians.

Education and Training. The training provided in family medicine at the College of Medicine at the U of S, both for undergraduate medical students and for residents in family medicine, is recognized as a genuine strength in the College. For example, U of S graduates are very successful in competing for internships and residencies in family medicine across the country.

Given that the assessment and treatment of mental health problems has a central place in quality primary health care services, appropriate educational and training experiences should increasingly be a priority for undergraduate students and residents in family medicine. The National Conjoint Committee on Mental Health Care (1996) emphasizes the value of the following training experiences in psychiatry for family medicine residents:

- contacts with psychiatrists and psychiatry residents in a variety of settings throughout their training;
- training on how to make optimal use of a psychiatric consultation or a psychiatrist who visits their office;
- an understanding of the principles of shared mental health care and ways in which psychiatrists can assist family physicians;
- exposure to role models who can work collaboratively with psychiatrists;
- practical experiences and supervision in working within models of shared mental health care.

The same kinds of learning experiences for family medicine students and residents with other mental health professionals could be recommended. Indeed, far closer integration and collaboration among the mental health professions in education and training, including continuing education, has been recommended for some years.

Continuing education opportunities for family physicians in mental health assessment and treatment is lacking. A family physician who practices psychotherapy full-time in the province reports that in the past five years only 12 credits of continuing education with any relevance to mental health have been offered; 24 credits are required for mandatory maintenance of proficiency with the College of Family Physicians of Canada.

Issues

There is a significant shortage of family physicians in rural Saskatchewan. A number of useful strategies for recruitment and retention are offered in the recent Health Action Plan. These, and others suggested below in Chapter 5 need to be funded and implemented.

Family physicians do not typically have sufficient expertise in providing mental health services to their many patients. This is particularly so in rural areas and among some foreign trained physicians. Requirements for further training in mental health service provision for untrained family physicians should be put in place. Continuing education opportunities and requirements in mental health services are needed. The place of mental health services within a primary health care service delivery model in the province requires articulation, planning, and additional resources.

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.

Education and training in mental health, including continuing education, is inadequate for family physicians. Enhanced training in mental health is desirable for undergraduate medical students and residents in family medicine; also needed are increased opportunities for continuing education in mental health for family physicians.

SOCIAL WORKERS

A profile of social workers in Saskatchewan is presented in Appendix 7, including summary information on supply, demographics, mental health services, working conditions, wages and salaries, and education and training programs. Some comparison data from other jurisdictions is presented. Issues with respect to competencies in the direct provision of clinical mental health services, definition of the scope of practice, and education and training for work in the mental health sector are discussed.

Supply. The number of social workers per population in Saskatchewan appears to be similar to the ratios in Manitoba and Canada, and higher than in Alberta. (The numbers reported by CIHI for 1997 and 1988 (Appendix 7, section 1.1) are collected differently from those I report for 2000 and can not be directly compared; comparisons across jurisdictions for 1997 and 1988 are meaningful using the CIHI data.) The number of social workers in the province appears to have increased significantly from 1988 to 1997.

Only social workers registered with the Saskatchewan Association of Social Workers are considered for the purpose of this report. The large majority have a Bachelors or Masters 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.

Location. Sixty percent of social workers are employed in Regina and Saskatoon, 40% in rural locations where there are only about one-half the number of social workers per population compared to the two cities.

Age. The average age (42) and age distribution of social workers is similar registered nurses in the province; LPNs, family physicians, psychiatrists and psychologists are older on average. Anecdotal information suggests that the cohort of social workers with MSWs practicing in the mental health sector are considerably older, the majority working in Saskatoon are within five years of retirement.

Gender. Seventy-nine percent of social workers are female, about the same proportion of psychologists who are female.

Aboriginal representation. In 1996, twenty-percent of social workers were of Aboriginal heritage, a significantly greater proportion than in any other jurisdiction in Canada including Manitoba (12%) and Alberta (10%). Today, given the sustained enrollments in the Bachelor of Indian Social Work program at SIFC (Saskatoon), it is likely that the proportion of Aboriginal peoples in the social work profession has increased since 1996. The large majority of graduates from the BISW at SIFC do not, it appears, register with the Saskatchewan Association of Social Workers. Anecdotal reports suggest that a significant number of BISW graduates are unemployed or underemployed in the province.

Employment and mental health services. The majority of social workers (56%) are employed in the health sector. Only 90 FTE social workers, however, are employed in mental health facilities in the health districts. Many of the rest of the social workers employed by health districts, it is assumed, are providing mental health services, broadly considered.

It is assumed that most of those employed in Social Services (10%), Community Based Organizations (10%), Justice (3%), school social work (4%), and those engaged in private practice (12%), provide what may be considered, broadly again, to be mental health services.

It is estimated, then, that 50-70% of the social workers registered in the SASW are providing primarily mental health services.

Many of the mental health services provided by social workers are common to all mental health professions. Social workers provide direct counseling and therapy services, case management, community development, supervision and consultation, and program management and administration (Canadian Association of Social Workers, 2001).

Competencies and scope of practice. The practice of social work has become increasingly complex and more specialized. The scope of practice of social work is defined in legislation in several jurisdictions in Canada, and the SASW has proposed a similar definition be incorporated in its *Act*:

> Social Work is the professional activity of enhancing or restoring the social functioning of individuals, families, groups and communities by means of assessment, remediation and the treatment of social and psychosocial problems.
>
> The practice of social work requires the application of social work values and knowledge of human development and behaviour; social, political, economic and cultural institutions; and, the interaction of all of these factors. The practice of social work shall include but not be limited to: policy development and program administration, clinical practice and counseling, community organization and development, advocacy, social research and social work education.

Working conditions. A new collective bargaining agreement signed between SAHO and the Health Science Association which became effective November 3, 2003, includes an overall salary increase of 21% over 3.5 years. This goes some way toward addressing retention and recruitment issues.

Hourly wages for social workers in the province are now 16% -18% higher than those in Manitoba, giving Saskatchewan a competitive advantage over Manitoba in recruiting and retaining social workers in the health sector. Wages for social workers are slightly higher in Alberta, especially maximum wages for MSWs (23% higher), except for minimum wages at the BSW level which are 11% higher here than in Alberta. However, the contract for Alberta social workers expired in 2001; a new contract will likely provide for significantly increased wages. Social workers in BC earn significantly higher wages, 9%-23% higher than in Saskatchewan. Wages in Saskatchewan are not sufficiently competitive with those in Alberta and BC for the recruitment and retention of social workers in the health sector.

Vacancy rates for social workers employed in the health sector have been at 4.4%, on average, during the last decade. The vacancy rate in 2000 was lower (2.3%). The turnover rate for social work positions is significantly higher in rural areas (5.9%) than in Regina and Saskatoon (2.5%).

Similar to other health workers, social workers also report high levels of workplace stress and poor morale. Concerns with respect to working conditions in the health sector were thoroughly reviewed in a recent report (Backman, 2000). These concerns and recommendations to address them are considered in Chapter 5.

Education and training. Bachelors and certificate programs in social work, at the U of R and SIFC, have enrolled at total of about 800 students in recent years, many are part-time students. Attrition from undergraduate social work programs is high, here and elsewhere. It appears that less than one-third of students enrolled in social work programs will graduate with degrees or

certificates. A total of about 270 students graduate each year with degrees or certificates in social work from the U of R and SIFC. The majority of these graduates will not pursue careers in health or mental health, and the majority do not register with the SASW. Rather, social work graduates find employment in a wide range of human service positions.

The BSW program at the U of R offers very limited training in the knowledge and skills related to the provision of direct clinical services in the mental health sector. Similar to many BSW programs in the country, the U of R program is a generalist one emphasizing social policy, administration, and general social and human services; traditional areas of practice such as child protection and income support are not given as much emphasis as they were in the past. One course is available in mental health programs and policy, and there are a few courses in which specific counseling approaches are covered. Some practicum experiences in mental health settings are also available to students.

The program does not provide sufficient training or beginning competencies for graduates to provide direct clinical services in mental health. BSW graduates are sometimes hired in direct clinical service positions in mental health and will require considerable training and close supervision over a couple of years to acquire the competencies needed. Without such training and supervision in the work setting, BSW social workers should not provide clinical, mental health services.

The MSW program at the U of R offers somewhat greater training in the provision of mental health services. Two or three courses are available to students: Counseling Theories and Social Work Practice, Social Work Practice with Individuals and Groups, Social Work Practice with Families. A few students will do a practicum in a mental health setting. It is the position of social work associations and regulatory bodies across North America that the MSW is normally required for clinical practice and counseling. Training in skill-based competencies for clinical practice and counseling in the MSW program at the U of R is very limited. The curriculum is undergoing revision at present. Many social workers who provide clinical, mental health services will pursue considerable continuing training, through workshops and supervision, to build their competencies. This is, indeed, essential given the relatively limited clinical training provided in the MSW program.

Issues

The issues particular to social workers in the mental health sector are: 1.) the need for better articulated competencies with respect to the provision of direct clinical services, including a definition of the scope of practice; and 2.) 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. Social work is relatively underdeveloped as a profession in the province.

Until 1995, the legislation regulating social work provided only for voluntary registration and regulation of members. The 1995 Act does not define the scope of practice of social work; only the title “social work” is protected. Thus, anyone may practice social work so long as they do not call themselves “social workers”. This is also the case in psychology. The lack of an agreed upon scope of practice, defined in legislation, is one indication of the underdevelopment of the profession.

Government can assist in the development of the profession in a number of ways: defining scope of practice in legislation; encouraging the development of standards for the practice of social work in health/mental health settings; providing funding for enhanced training in clinical social work in post-secondary institutions and targeted funding for continuing education and professional development.

PARAPROFESSIONALS AND OTHER PROFESSIONALS IN MENTAL HEALTH

Profiles for the various paraprofessionals who provide mental health services in the province have not been prepared for this report. Databases are not readily available in most cases, unfortunately. It is important to note, however, that a good deal of the front line care provided to those with mental illness is being provided by paraprofessionals in the specialty mental health sector, the general health/medical sector. These paraprofessionals are briefly considered here, along with the education and training programs available for them in post-secondary institutions.

Mental Health Sector

Residential care is provided for mentally disordered persons by about nine **residential service associations** in the province. Staff are paraprofessionals who typically have university courses or degrees in social science fields or social work, or have completed some training at SIAST.

In addition, there were 230 approved homes providing residential care for 846 mentally disordered persons in 1999-00. **Operators of approved homes** are nonprofessionals who typically do not have any formal education or training in mental health.

There appear to be about 30 **mental health therapists** employed by health employers in mental health services, mostly in rural areas. These paraprofessionals typically have university courses or degrees in the social sciences or social work, or have completed some training at SIAST.

At least 139 **addictions workers/counselors** (Saskatchewan Health, 2000 Health Employer Survey) are employed in the health sector. These paraprofessionals typically have university courses or degrees in the social sciences or social work, or have completed some training at SIAST.

In the schools, at least 67 **school counselors** are employed in work in the mental health area (Saskatchewan Health, 2000 Health Employer Survey). These paraprofessionals typically have university degrees in Education, some have training in special education.

General Health/Medical Sector

A number of the aides that are employed in health provide care for the mentally ill, particularly in long term care facilities and in home care in the province. Some of these aides may have some training at SIAST related to care of the mentally ill. In 2000, there were at least 4555 **special care/health care aides**, 2030 **nurses aides**, and 1926 **home care aides** (Saskatchewan Health, 2000 Health Employer Survey; counting all full-time, part-time, and casual positions).

In a recent study of Home Care/Special Care Aides in Saskatchewan (Saskatchewan Health, Labour Market Study of Home Care/Special Care Aides in Saskatchewan, 2001) the following concerns about training were reported:

- there has been decreased emphasis on orientation, training and professional development offered by health districts in recent years;
- there are concerns about the availability, cost and the quality of certificate programs offered by SIAST for Special Care Aides and Home Care Aides, and at SIIT for Home Health Aide/Long-Term Care Aide;
- there is a lack of adequate continuing training opportunities and funding.

Recreational therapists and technologists in health care also provide care for mentally ill, particularly in long term care facilities in the province. In 2000, there were at least 74 therapists and 92 technologists employed in health (Saskatchewan Health, 2000 Health Employer Survey).

Finally, **professionals in occupational therapy** (at least 174 positions, Saskatchewan Health, 2000 Health Employer Survey) and **speech and language pathology** (at least 143 positions, Saskatchewan Health, 2000 Health Employer Survey) who are employed in the health sector provide their specialized services to some who are mentally disordered.

Competencies for Paraprofessionals in Mental Health

The International Association of Psychosocial Rehabilitation Services (2002) has recently implemented a certification program for paraprofessionals in working in community-oriented rehabilitation services for persons with psychiatric disability. Requirements for certification are:

- Education and Work Experience:
    - a bachelor's degree in a mental health area and one year of appropriate work experience;
    - or a bachelor's degree in an unrelated area, plus 60 hours training in psychiatric rehabilitation and one year of appropriate work experience;
    - or a high school diploma, plus 60 hours training in psychiatric rehabilitation and two years of appropriate work experience;
- Professional references
- Written exam on seven practice domains: interpersonal competencies; professional role competencies; community resources; assessment, planning and outcomes; systems competencies; interventions; and diversity.

These are a reasonable set of minimum competencies for paraprofessionals in mental health in the province that merit careful consideration by all employers and educators.

Post-Secondary Programs and Courses Relevant for Care of the Mentally Ill

SIAST

- Home Care/Special Care Aide Certificate Program, offered as both pre-employment (30 weeks duration) and on-the-job training (5 years part-time) programs;
- Chemical Dependency Worker Diploma and Certificate Programs;
- Corrections Worker;
- Early Childhood Education Diploma and Certificate Programs;
- Rehabilitation Worker Diploma and Certificate Programs;
- Occupational Therapist Assistant/Physical Therapist Assistant;
- Youth Care Worker Diploma and Certificate Programs;

- Provincial Corrections Worker Applied Certificate Program;
- Dementia Care Applied Certificate Program;
- Fetal Alcohol Syndrome Course.

Saskatchewan Indian Institute of Technologies (SIIT)

- Home Care/Special Care Aide Certificate Program (32 weeks full-time; 5 years part-time, on-the-job);
- Community Services, Addictions;
- Community Health Representative;
- First Nations Child Care.

Saskatoon Business College

- Personal Care Aide Certificate Program (24 weeks full-time)

PRIVATE PRACTICE SECTOR IN MENTAL HEALTH

The results of a survey of private practitioners in mental health undertaken for this study are found in Appendix 8. A similar survey was reported by Suurkivi (1999). The population sampled was the same, i.e. mental health practitioners who advertise in the Yellow Pages throughout the province; Suurkivi's response rate was higher (52% compared to 30%); the results she reports are very similar to the results of this survey.

Highlights of the survey of private practitioners are summarized.

- 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);
- Fifty percent are located in Saskatoon, 30% in Regina, 20% in rural areas;
- Their average age is 48 years;
- About one-half are male, and half are female;
- About one-third are not registered members of a health profession; one-third are social workers, 25% are psychologists;
- About one-half have master's degrees, one-quarter doctoral degrees, one-quarter bachelor's degrees, and 5% certificates or diplomas;
- They provide an average of about 25 hours per week of private services;
- Therapy/counseling is the primary service provided, accounting for about two-thirds of their work, most of which is provided to adult clients;
- The most frequent problems they treat are associated with marriage and family relationships (29%), abuse-related difficulties (15%), mood disorders (13%), anxiety disorders (10%), and adjustment and stress problems (11%);
- Their gross annual income from private practice is $47,451.00, on average; average hourly fees are $75.00;
- 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).

Caution is required in interpreting these results as the sample sizes represent only 30-50% of the estimated 250 private practitioners in the mental health sector.

Issues

Private mental health services are increasingly being provided, mainly by social workers and psychologists; in addition, one-third are unregulated therapists/counselors. If this sample is representative of all private practitioners, then the extent of private mental health services amounts to about $12 million annually, about 160,000 billable hours of mental health service.

Should providers of private mental health services who are not registered health professionals be regulated? One option is to define scope of practice of social work and psychology in legislation, in an attempt to then exert some greater control over the expansion of unregulated therapists/counselors.

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.

Chapter Five

Key Issues and Recommendations

Key issues are highlighted and recommendations offered in four areas: supply and recruitment in the mental health workforce; working conditions and retention; enhancement of mental health services; and policy.

Recommendations are not prioritized. Rather, stakeholders are agreed that establishing priorities and working to implement the recommendations is the joint responsibility of the stakeholders themselves in collaboration with the Government of Saskatchewan and Regional Health Authorities.

1. Supply and Recruitment in the Mental Health Workforce

Workforce issues within each of the seven professions, and paraprofessionals, were identified in Chapter 4. There are clearly a number of key issues that apply to all or most of the professions in the mental health workforce. These are identified and recommendations offered here. Recommendations for particular professions are offered where necessary.

Education and training issues within each of the seven professions, and paraprofessionals, were identified in Chapter 4. There are clearly a number of key issues that apply to all or most of the professions in mental health. These are identified and recommendations offered here. Recommendations for education and training within particular professions are offered where necessary.

1.1 General Strategies

Among the various recruitment strategies recommended recently for health professions the following are recommended for mental health professions:

- enhancement of post-secondary education and training programs and seats in order to increase the supply of provincially trained graduates; increased co-op, practicum, internship, and other clinical training experiences in the province;
- student bursary programs;
- improved job security—full-time permanent entry-level positions;
- financial incentives—signing bonus, moving expenses, temporary housing;
- finding jobs for spouses, particularly in rural areas;
- guaranteed opportunities for continuing education and professional development;
- opportunity for appointment or affiliation with a university program;
- mentoring programs;
- peer support networks for those in rural communities;
- requiring that Regional Health Authorities that have vacancies in key positions use the funding to provide equivalent services through alternative arrangements.

1.1.1 Recruitment strategies should be targeted to attract mental health professionals in areas where the service needs are most urgent: child, youth and family, forensic, community care of the severely mentally disabled, geriatric, addictions and mental health, Aboriginal mental health, and mental health services in primary care.

1.1.2 Aboriginal access programs in a number professional and paraprofessional training programs are needed: family medicine, psychiatry, psychology, corrections workers, recreational therapists/technologists, early childhood development/child care workers, and addictions counselors.

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

1.2 Mental Health Specialists

Training programs for the mental health specialists: psychiatry residents, predoctoral psychology interns, clinical, counseling and school psychologists, and clinical social workers all are relatively under resourced. Universities operate autonomously, allocating their resources as they see fit; and, the universities are relatively under resourced today.

1.2.1 Given the chronic need for mental health professionals, it is recommended that government provide targeted funding to the two universities for the training of key mental health professionals in psychology and social work.

The shortages of psychiatrists and psychologists are well known. The serious limitations in mental health services in the province are the direct result of decades of inadequate numbers of psychiatrists and psychologists to provide necessary leadership. Renewed, innovative recruitment strategies are required at attract and keep psychiatrists and psychologists.

1.2.2 Psychiatry residency training requires additional resources for training in child and youth, geriatric, and primary/shared care. The number of residents trained, three per year, should be increased.

1.2.3 The critical issues that need to be addressed in recruiting and retaining psychiatrists have been addressed in the Psychiatry Human Resource Plan 2001. The recommendations offered should be implemented immediately. Psychiatrists skilled in community mental health who can contribute to primary care are particularly needed.

Psychology practicums are provided within hospital-based and community-based services as a component of master's and doctoral university programs. Incremental funding is required for the one year of pre-doctoral internship training required in clinical psychology. The number of interns in the program at RUH/SDH is currently 2. Regina presently has no program and no funding for one.

1.2.4 The number of interns trained in the pre-doctoral internship program at RUH/SDH should be expanded from 2 to 6 per year. Pre-doctoral internship training should be established in Regina, perhaps in a consortium with RUH. Training opportunities in rural and Northern sites should be developed as part of these pre-doctoral internship programs.

Psychology doctoral programs in clinical psychology at the two universities should enhance training in evidence-based therapy, such as cognitive-behavioural therapy, multisystemic therapy, assertive community treatment, applied behavioural treatments for children. The program at the U of R requires one or two additional faculty in order to apply for accreditation. The number of students in both programs should be increased.

1.2.5 The number of doctoral students in clinical psychology educated in the Departments of Psychology at U of R and U of S should be increased. Particular attention should be paid to increased numbers of Saskatchewan residents in both programs.

The planned enhancements to masters and doctoral training for counseling and school psychologists in the Department of Educational Psychology and Special Education at the U of S should be implemented; this will increase the supply of masters' level psychologists in counseling and school psychology.

1.2.6 Revisions being planned for the Master's program in counseling psychology in the Department of Educational Psychology and Special Education at the U of S should be supported.

1.2.7 The Department of Educational Psychology at the University of Regina should review its master's program in terms of the quality of the program in preparing graduates for employment in mental health and for private practice.

A group of psychologists in the Regional Health Authorities is currently preparing a human resource plan. Recruitment of doctoral clinical psychologists who are trained in the province should be a priority; about one-half in recent years have remained in Saskatchewan after completing their training.

1.2.8 The recommendations of the Psychology Working Group should be carefully considered and implemented.

The large decrease in the numbers of nurses registering with the Registered Psychiatric Nurses Association of Saskatchewan needs to be addressed immediately.

1.2.9 RPNAS and NEPS should collaborate to develop an aggressive marketing program aimed at attracting more students and prospective students into careers in psychiatric/mental health nursing.

As there is presently no educational program for RPNs in the province that is approved by the RPNAS, resolution of issues in the training of prospective RPNs between the RPNAS and NEPS requires immediate attention.

1.2.10 If the present negotiations between the RPNAS and NEPS fail to reach a resolution satisfactory to both parties, the Government of Saskatchewan should make alternate arrangements for training registered psychiatric nurses that will ensure a continued supply of RPNs for the province.

1.3 General Medical/Primary Care Sector

In the general medical/primary care sector, there are immediate needs for family physicians and advanced nurse practitioners with expertise in mental health, particularly in rural Saskatchewan.

Enhanced resources for training in mental health are also needed for family medicine residents, and nursing students in NEPS and the Masters' program. Family physicians and nurses devote very considerable time to the care of patients with mental disorders and problems. They are not sufficiently well trained in mental health. LPNs would benefit from greater training in mental health.

1.3.1 The residency program in Family Medicine should incorporate greater training in shared care with psychiatrists and psychologists; likewise, psychiatry and clinical psychology programs should include training in shared care with family physicians.

1.3.2 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.

1.3.4 Continuing education programs in mental health for family physicians and nurses working in primary care, long term care, home care, and community health should be expanded.

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

1.4 Social Work

1.4.1 The Bachelors and Masters programs in Social Work at the U of R should be revised to include greater training in clinical mental health work.

1.4.2 The Bachelors and Masters programs in Indian/First Nations Social Work at the SIFC should be revised to include greater training in clinical mental health work.

1.5 Paraprofessionals

A good number of programs and courses related to mental health care are offered through SIAST and SIIT for paraprofessionals: aides, corrections workers, recreational therapists/technologists, early childhood development/child care workers, and addictions counselors. There are concerns among mental health specialists about the quality of some of these programs that warrant attention.

1.5.1 Courses and programs for paraprofessionals in the mental health sector at SIAST require review with the aim improving the quality of training available for the large numbers of mental health paraprofessionals who access them.

2. Working Conditions and Retention in the Mental Health Workforce

In the recent report, *Job Satisfaction, Retention, Recruitment and Skill Mix for Sustainable Health Care System*, Backman (2000) recommended a number of changes in the health workplace required to enhance retention. The following are applicable in the mental health sector, in particular:

- holding managers and authorities accountable for retention;
- identification, recognition and rewards for high-potential workers;
- placing professional clinicians in key leadership/management positions;
- tailoring retention strategies to the life-cycle of employees;
- increase the valuing and respecting of professionals' autonomy;
- fully involving professionals in planning and decision-making;
- opportunities and funding for continuing education and professional development;
- formalized system of peer support, including case consultations and continuing education experiences.

Psychologists across the country were recently surveyed (Canadian Psychological Association, 2001) to ascertain the reasons why so many were leaving employment in the health/mental health public sector in favour of private practice. The concerns were similar to those Backman heard from health workers of all kinds in Saskatchewan.

For psychologists, the flight from the public to the private sector is largely a function of deteriorating working conditions resulting in increased workloads and inappropriate treatment programs, highly bureaucratic workplaces that allow less flexibility and autonomy, and reductions in health spending that, in the view of psychologists, have not always been guided by careful assessment of clinical needs, treatment efficacy or cost-effectiveness.

2.1 Backman's recommendations for enhancements in the workplace should be implemented by Regional Health Authorities in collaboration with the Department of Health, unions, professional associations, and post-secondary programs.

2.2 Wage increases and improvements in working conditions are required for staff in Community-Based Organizations working with the mentally ill.

A very important concern, raised also by Backman (2000), is the lack of opportunities for continued education and professional development. Saskatchewan Health hosts two workshops each year for mental health professionals. More is required. This is a critical concern for recruitment and retention, and for enhancing the quality of mental health services in the province.

2.3 Government, regional health authorities, professional associations and regulatory bodies, along with post-secondary institutions must all commit themselves to addressing this urgent need. 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.

3. Enhancement of Mental Health Services

3.1 Health

3.1.1 Significant enhancements to child and youth mental health services are needed, particularly with respect to providing for full continuum of care (case management, day treatment, alternate residences, and in-patient treatment).

3.1.2 Primary prevention programs, particularly for children and youth, are needed.

3.1.3 Mental health services for geriatric patients and older adults are severely limited in the province. Integrated mental health services in geriatrics are required. A provincial plan and an Integrated Services Forum are desirable.

3.2 Voluntary and Informal Support Sector

3.2.1 Incremental investments are required for consumer self-help, consumer-operated programs, and informal support networks for families who care for their mentally ill children and older adults.

3.22 Enhancements to community development programs are needed in order to build community resourcefulness in caring for the mentally ill, particularly in rural Saskatchewan.

3.3 Mental Health Workers in the Human Service Sector: Social Workers, Human Service Workers

Social Services

3.3.1 Mental health consultants, training for workers, and enhanced mental health services are required in Social Services for programs in Building Independence, and in child protection, therapeutic foster care, young offender programs, and children's facilities.

3.3.2 Applied behavioural therapy specialists are needed in Community Living to work with the intellectually disabled.

Learning

3.3.3 Significantly more school psychologists and special education specialists are needed.

3.3.4 Mental health consultants and workers are required in community schools.

3.3.5 Enhanced funding and programming in Kids First (Early Childhood Intervention) is needed, particularly for FAS prevention and early intervention in Aboriginal communities in the North and in urban centres.

Corrections

3.3.6 Mental health professionals and services in the corrections centres, in probation services, and in community programs are required, particularly for youth.

3.3.7 Implementation of evidence-based treatment programs in mental health and substance abuse in corrections is required.

4. Mental Health Policy

4.1 Competencies and Scopes of Practice

There are concerns within each of the three nursing professions about their scopes of practice and the lack of opportunity to work to the full scope of their competencies in the workplace. With respect to the mental health sector:

4.1.1 The basic competencies for RPNs are too broad to be meaningfully applied; still, the competencies of RPNs in mental health care are, or should be, recognized as distinct in nursing; the scope of practice of RPNs should be defined in legislation.

4.1.2 A broader scope of practice of 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.

4.1.3 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.

It appears that Collective Bargaining Agreements for nurses place greater emphasis on seniority rights than on demonstrated competencies in the mental health sector. Also, seniority clauses and an inadequate number of positions appear to present barriers to hiring recent graduates into full-time positions in the mental health sector.

4.1.4 Competencies in mental health care should take precedence over seniority in hiring and promotion decisions.

Defining the scope of practice of psychologists and social workers in legislation is desirable as this is the primary way in which the private mental health practice of non-regulated counselors can be monitored to better protect the public from practices that in some few cases may be harmful. There are, however, practical reasons why this may be challenging: it is difficult to find language to appropriately define the broad scope of practice of these professions; agreement of other health professions whose scopes of practice may overlap with psychology and social work is required; successful prosecution may be difficult and can be costly to professional associations.

4.1.5 Scope of practice should be defined in the Acts respecting the professions of Psychology and Social Work.

Competencies in mental health care among some family physicians/general practitioners, particularly some that are foreign trained, appear to be inadequate.

4.1.6 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.

4.2 Department of Health and Regional Health Authorities

4.2.1 The Quality Council should address mental health as a priority issue. It should:

- **establish indicators for population mental health, monitor these and report regularly.**
- **establish indicators for social determinants of health and mental health, monitor these and report regularly.**
- **monitor access to evidence-based mental health treatments, such as cognitive-behaviour therapy, assertive community treatment, multisystemic therapy.**

4.2.2 Study of the rapidly growing private sector in mental health services compared to the inadequate access in the public sector is needed. Policy development is required to address a growing inequity in access to mental health services between those who can afford to pay privately and those who can not.

4.2.3 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.

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

4.2.5 Mental health must be an integral part of Aboriginal health policy and programs. A study focusing on policy and programming for Aboriginal mental health in Saskatchewan, in partnership with the FSIN, should be considered by Government.

4.3 Human Service Sector, Department of Social Services

4.3.1 Incremental investments in social housing for the mentally disabled are required.

4.4 Government Decision Making and Priority Setting in Mental Health

To facilitate a process of decision-making and priority setting in the Government of Saskatchewan, I offer the following recommendations.

4.4.1 This report should be reviewed by appropriate units and committees in the Department of Health (Community Care, Primary Health Services, Population Health, Policy and Planning, Advisory Committee on Mental Health, Health Human Resources Council) and the Department of Learning (Programs, Institutions, University Services, Policy and Evaluation).

4.4.2 This report should be reviewed by managers and key people in the specialty mental health sector (including the Regional Health Authorities, Professional Associations and Regulatory bodies), the general medical/primary care sector, the human service sector, the voluntary sector, unions, and post-secondary institutions.

4.4.3 Following reviews, senior management in the Department of Health and the Department of Learning should reach a decision about the extent to which they wish to proceed on the issues and recommendations made in this Report, and the priority to be given to advancing initiatives in the mental health system.

4.4.4 Incremental funding for mental health is necessary in order to act on a reasonable number of the recommendations. In the Department of Health, mental health's share of the budget has decreased in recent years. Increasing funding for mental health from its current 3.5% of the total Health budget to 5% would increase funding for mental health from about $80 million to $115 million in 2002-03. This is the order of additional funding—reallocated, and/or cost-shared among Departments, and/or incremental--required to make mental health a priority in health care.

4.4.5 If priority is to be given to advancing a mental health agenda, then an intersectoral committee of Assistant Deputy Ministers should be established with representation from appropriate Departments (Health, Social Services, Learning, Corrections and Public Safety, Government Relations and Aboriginal Affairs). This committee should be responsible for advancing a strategic plan for the mental health system to be presented to Cabinet. In the spirit of enhancing the priority given to mental health, I note that the Government of British Columbia recently established a Ministry of State for Mental Health.

4.4.6 Further, it is recommended that an intersectoral committee on mental health consult widely with stakeholders; consultations could be launched with an invitational conference for key stakeholders representing the broad mental health system and post-secondary education.

5. Next Steps

It was agreed at a meeting on June 26, 2002 that the Mental Health Workforce referent/stakeholder group that was put together for this study should continue to function. Each of the professional associations and regulatory bodies, unions, education and training institutions, and consumer groups that participated in the study will be asked to continue their participation.

The initial tasks of the Mental Health Workforce Stakeholders are to:

- disseminate this Final Report and develop a strategy for communicating the key findings and recommendations;

- prioritize the recommendations made in this Final Report;
- work to facilitate the implementation of priority recommendations.

It was agreed that one of the priorities for the Mental Health Workforce Stakeholders is to enhance mental health services in primary care health care. 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*.

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Appendix 1

PROFILE OF SASKATCHEWAN REGISTERED PSYCHIATRIC NURSES

1. DEMOGRAPHICS

1.1 Number of RPNs

	Saskatchewan[13]				Other Jurisdictions MB[11]	AB[12]	CAN
	2000	**1999**	**1998**	**1997**	**2000**	**2001**	
Total	1119	1160	1196	1234	1026	1165	
Active	1051	1089	1112	1137			
Ratio of RPNs to population							
Total RPNs	1/916				1/1120	1/2584	
Active RPNs	1/970						

1.2 Location[13]

	No.	%	Ratio of active RPNs to population
Urban	478	45	1/939
Regina	274	26	1/773
Saskatoon	204	19	1/1163
Rural	572	55	1/997
Moose Jaw	154	15	
North Battleford	133	13	
Prince Albert	99	9	
Yorkton	87	8	
Weyburn	69	7	
Swift Current	30	7	

Sources for all data referenced by footnotes are in Appendix 9

1.3 Age[13]

Average age	42.1

Age distribution (2000)

25 and under	4%
26-35	26%
36-45	45%
46-55	26%
56+	9%

1.4 Gender[13]

(active practicing RPNs, 2000)

Female	84%
Male	16%

2. PRACTICE

2.1 Employment And Practice Area[13]

Employer	No.	%
Hospital	382	34
Special Care Home	243	22
Government	180	16
Community Service	120	11
NGO	51	5
Home Care	19	2
Post-Secondary	16	1
Independent Practice	6	0 .5
Private Nursing Service	4	0 .5
Other/unknown	98	9

Primary Practice Area	No.	%
Acute Care	258	23
Geriatric	295	26
Mentally Disabled	127	11
Rehab/Vocational	111	10
Forensic	90	8
Child & Youth	42	4
Addiction	24	2
Home Care	24	2
Other/unknown	111	10

2.2 Employed in the Health Sector[3]

(incomplete data, 79% overall response rate)

Total Number	830
FTE	611

2.3 RPNs and RNs Employed by Health Districts in Mental Heath[7]

	FTE	**Percent of Total**
Urban	173	57
Regina	76.4	25
Saskatoon	96.6	32

Rural	130.2	43
East Central	26.7	9
Prince Albert	35.8	12
Battlefords	21	7
Moose Jaw/TC	21.8	7
South Central	14.4	5
Swift Current	10.5	3
Total	303.2	100

3. Working Conditions

3.1 Vacancy Rate in the Health Sector[3]

	2000	**1996-99 average**	**1991-95 average**
Urban	3.8%		
Rural	7.1%		
Overall	5.4%	1.9%	2.8%

3.2 Turnover Rate In the Health Sector[3]

Urban	1.7%
Rural	5.1%
Overall	3.4%

3.3 Wages and Salaries

		Other Jurisdictions		
	Saskatchewan	**MB**	**AB**	**BC**
General duty RPN and RN[37]				
Minimum hourly wage	$23.00	22.02	24.70	24.70
Maximum hourly wage	$27.62	25.96	32.42	32.42
Contract expiry date	03/31/05		03/31/03	03/31/04

* Rates are for 2002-03, as of March 31, 2002; Saskatchewan rates are for the Collective Bargaining Agreement reached by SUN and SAHO in April, 2002

4. EDUCATION AND TRAINING PROGRAMS

4.1 SIAST, Wascana Institute, Psychiatric Nursing Program[15]

(program terminated in 1997)

	1997	1996	1995	1994	1993	1993-97 average
Number of graduates	49	52	56	64	65	57
Number who registered with RPNAS one year after graduating	40	29	39	56	50	43 (75% of graduates)
Graduate employment statistics						
Percent employed in training Related employment	81	58	81	85	75	76%
Percent employed full-time in training related employment	42	16	47	45	22	34%

4.2 Nursing Education Program of Saskatchewan[16]

(program implemented in 1996)

	2001	2000	1999	1998	1997	1996
Number of students admitted	271	264	271	216	192	201
Number of graduates						
Diploma		3	14			
Degree	162	98	60			
Number of graduates who were registered with RPNAS one year after graduating		3	4			
Number of graduates who successfully wrote the licensing exam for SRNA		123	12			

4.3 Nursing Division, SIAST, Wascana, Psychiatric Nursing Re-entry Program (Distance) [15]

Appendix 2

PROFILE OF SASKATCHEWAN PSYCHOLOGISTS

1. DEMOGRAPHICS

1.1 Number of psychologists

	2002	2000				1997			
	SK	SK[27]	MB[28]	AB[29]	BC	SK	MB	AB	CAN
Registered psychologists	80[27]	75	250	1889					
Ratio of Registered Psychologists To population		1/ 13,663	1/ 4595	1/ 1594		1/ 14,617	1/ 7417	1/ 2033	1/ 2662

Expected in the College of Psychologists[30]	
Former SPA	80
Approved applicants	175
Applicants in process	(80)
Total expected	(335)
Expected ratio of Registered Psychologists To population	1/3053

1.2 Age

		Other jurisdictions		
		MB	AB	CAN
Average age[3]	(45.5)			

1.3 Gender[3]

Female	(72%)
Male	(28%)

Sources for all data referenced by footnotes are in Appendix 9

2. EMPLOYMENT AND MENTAL HEALTH SERVICES

2.1 Employed in the Health Sector[3]

(incomplete data, 79% overall response rate)

	FTE	FTE/1000
Urban	67.9	.151
Regina	22	.1
Saskatoon	45.9	.2
Rural	64.2	.112
Total	132	.1

2.2 Psychologists Employed by Health Districts in Mental Heath[7]

	FTE	Percent of Total
Urban	44.8	69
Regina	20	31
Saskatoon	24.8	38
Rural	19.7	31
East Central	3	5
Prince Albert	4.5	7
Battlefords	4	6
Moose Jaw/Thunder Creek	2.2	3
South Central	3	5
Swift Current	3	5
Total	64.5	100

3. WORKING CONDITIONS

3.1 Vacancy Rate in the Health Sector[3]

	2000	1995-99 average	1990-94 average
Urban	6.1%		
Rural	13.3%		
Overall	9.9%	8.2%	11.1%

3.2 Turnover Rate in the Health Sector[3]

Urban	8.5%
Rural	3.3%
Overall	11%

3.3 Wages and Salaries[38]

		Other jurisdictions		
	SK	**MB**	**AB**	**BC**
Masters				
Minimum	$24.15	$22.06	$25.16	
Maximum	$31.73	$28.54	$32.28	
Doctoral				
Minimum	$30.97	$26.47	$30.36	$31.79
Maximum	$40.38	$41.10	$38.95	$42.72
Date effective	11/03/02	04/01/01 contract expired	08/01/01 contract expired	04/01/02

* Assumptions have been made by SAHO on job matches between jurisdictions.

4. EDUCATION AND TRAINING PROGRAMS

4.1 Department of Psychology, Clinical Psychology Ph.D. Program, U of S[31]

	2001	**2000**	**1999**	**1998**	**1997**	**1996**
Number of applicants	50	60	70	80+		
Number of students admitted	5	4	4	6		
Number of graduates						
Ph.D.	5	6	5	6		
Follow up of graduates						
Percentage of graduates who entered practice in the province	50% over the last five years					

4.2 Department of Educational Psychology & Special Education, Graduate Programs, U of S[32]

	2001	2000	1999	1998	1997	1996
Number of applicants	51	21	38	48	48	
Number of students admitted	32	19	12	13	12	
Number of graduates						
Post graduate Diploma	1	2	2	5	4	1
M.Ed.	16	11	14	14	5	20
Ed.D.	0	1	0	1	0	0
Follow up of graduates						

4.3 Department of Psychology, Clinical Psychology Graduate Program, U of R[33]

	2001	2000	1999	1998	1997	1996
Number of applicants						
Number of students admitted	6	7	6	9	6	
Number of graduates						
M.A.	4	3	8	7	3	3
Ph.D.			1			1
Follow up of graduates						
Number of graduates who entered practice in the province	0	1	2	1	2	2

4.4 Department of Educational Psychology, Graduate Programs, U of R[34]

	2001	2000	1999	1998	1997	1996
Number of applicants						
Number of students admitted	7-10	7-10	7-10	7-10		
Number of graduates						
Post graduate Diploma						
M.Ed. (estimate)	7	7	7	7		
Ed.D.						
Follow up of graduates						
Estimated percentage of graduates who were employed (or remained so) in the province	more than 50% in recent years					

4.5 Department of Clinical Health Psychology, Predoctoral Internship Program, Royal University Hospital/SDH[35]

	2001	2000	1999	1998	1997	1996
Number of applicants	32	35	35	35	35	35
Number of interns admitted	2	2	2	2	2	2
Number of graduates	2	2	2	2	2	2
Follow up of graduates						
Percentage of graduates who Entered practice in the province	50% in the past five years					

Appendix 3

PROFILE OF SASKATCHEWAN PSYCHIATRISTS

1. DEMOGRAPHICS

1.1 Number

	Saskatchewan			Other Jurisdictions MB	AB	CAN
	2000	**1994**	**1992**	**2000**	**2000**	**2000**
Total	68	75[10]	96[10]			
Certified[2]	45			135	256	3875
Not Certified[7]	23					
Ratio of Certified[2] Psychiatrists to population	1/22,681			1/8513	1/11,808	1/7967
Ratio of Certified And Not Certified Psychiatrists To Population	1/14,992					

1.2 Location

Number of Psychiatrists on contract/ employed by Health Districts/Boards in Mental Health (does not include private practice psychiatrists) [7]

	Certified	Not Certified	Total
Urban			
Regina	4.8FTE	4	8.8
Saskatoon	3.1FTE	0	3.1
Rural	3	19	22
Total	10.9	23	33.9

Sources for all data referenced by footnotes are in Appendix 9

1.3 Age

Years since M.D. graduation[2] (Certified only)	SK	Other jurisdictions MB	AB	CAN
1-5	0	1%	3%	2%
6-15	27%	27%	28%	22%
16-25	28%	36%	33%	32%
26-35	20%	26%	22%	25%
35+	24%	10%	13%	19%

46% of all psychiatrists (including non certified) practicing in Saskatchewan are age 50 and over; 27% are age 60 and over.[9]

1.4 Gender[2]

(Certified only)

	SK	MB	AB	CAN
Female	36%	28%	27%	34%
Male	64%	72%	73%	65%

1.5 Foreign Trained Psychiatrists[2]

Proportion of Certified Psychiatrists whose MD is from a Foreign country	SK	MB	AB	CAN
	56%	13%	28%	32%

2. PRACTICE

2.1 Practice Settings

	Certified	Not Certified
Health District/Board[7]	10.9	23
Private practice	34.1	

Mental Health Services by Diagnosis
Provided by all Physicians (Psychiatrists and GPs) [7]

Diagnosis	**Private Physician Services**[a] (% of total)	**Inpatients**[b] Separations[c] number	% of total	Average Length of Stay (days)
All psychotic disorders		1164	24	20
Schizophrenic psychoses	4.8			
Affective psychoses	9.8			
Dementias and senile organic psychotic conditions	2.2	213	4	25
Neurotic/anxiety disorders	23	198	4	10
Personality disorders	0.7	76	1.58	
Sexual deviations & disorders	0.9	1	<1	8
Eating disorders		40	<1	41
All substance-related disorders		537	11	7
Alcohol dependence	2.6			
Drug dependence	3.1			
Nondependent abuse of drugs	2.2			
Adjustment reaction	4.2	310	6 8	
Acute reaction to stress	0.9			
Depressive disorders	24.5	1927	3916	
All childhood, adolescent disorders		223	4.5	10
Disturbance of conduct	2.7			
Attention deficit disorder	3.5			
Developmental delays and mental retardation	0.9			
All other childhood disorders	0.2			
All other disorders & unclassified	13.9	213	412	
Total		4902		15 (average)

[a] Physician services (Psychiatrists and GPS) for mental health reason, 1999-2000, private practice only, excludes contract psychiatrists
[b] Nine inpatient mental health units, excludes SHNB
[c] Similar to admissions data, hospital separations include all discharges and other departures

N.B. *In addition to 4902 separations from these nine inpatient mental health units, there were another 2077 psychiatric patients separated from non-psychiatric units in hospitals in Saskatchewan; 94% of these patients were in health districts without inpatient mental health units. The average length of stay for these psychiatric patients was 6 days.*

2.3 Saskatchewan Hospital North Battleford Psychiatric Patients, 1999-2000[7]

Average number of patients	161
Number of admissions	175
Number of separations	162
Proportion of forensic admissions	78%
Average length of stay for forensic patients	34 days
Average length of stay for all inpatients, March 31, 2000	9.8 years

3. EDUCATION AND TRAINING PROGRAMS

College of Medicine, U of S, Psychiatry Residency Program[8]

	2001	**2000**	**1999**	**1998**	**1997**
Number of applicants					
Number of residents admitted	3	3	3	3	3
Number of graduates	3	3	3	3	3
Number of graduates who enter practice in the province	an estimated 30-40% over the past five years				

Appendix 4

PROFILE OF SASKATCHEWAN REGISTERED NURSES

1. DEMOGRAPHICS

1.1 Number of RNs

	Saskatchewan[17]					Other Jurisdictions[17]		
	2001	**2000**	**1999**	**1998**	**1997**	**MB**	**AB**	**CAN**
		2000				**2000**	**2000**	**2000**
All RNs		8689				10,287	23,406	254,628
Employed RNs	(8276)[18]	8543	8553	8455	8356	10,051	22,172	232,412
Ratio of employed RNs to population[19]		1/120				1/114	1/136	1/133
Number of employed RNs per 10,000[17]		83.5	83.5	82.4	82.6	87.5	73.6	75.4

1.2 Age[17]

		Other jurisdictions		
	SK	**MB**	**AB**	**CAN**
Average age	43.6	43.2	43.4	43.3
Age distribution				
Under 25	1%			
25-34	18%			
35-44	32%			
45-54	34%			
55+	14%			

1.3 Gender[17]

Female	97.3%	95.6%	97.4%	95.2%
Male	2.7%	4.4%	2.6%	4.8%

Sources for all data referenced by footnotes are in Appendix 9

2. EMPLOYMENT AND PRACTICE AREAS

2.1 Employment Status[17]

		Other jurisdictions		
	SK	**MB**	**AB**	**CAN**
Full-Time	51%	45%	54%	50%
Part-Time	37%	55%	45%	41%
Not Stated	12%	0	0.2%	4.3%
Single employment	79%	87%	83%	80%
Multiple employment	21%	13%	17%	15%
Not stated	0.4%	0	0	5%

2.2 Place of Employment[17]

Hospital	**59%**	**65%**	**66%**	**64%**
Hospital (general, maternal, paediatric, psychiatric)	55%	61%	63%	61%
Mental Health Centre	0.7%	0.4%	1%	1.6%
Nursing Stations (outpost or clinics)	1%	1.3%	0.7%	0.7%
Rehab/Convalescent Centre	1.5%	2.5%	1.3%	1%
Community Health	**17%**	**9%**	**12%**	**12%**
Health Centre	10%	6%	7%	9%
Home Care	7%	3%	5%	4%
Nursing Home/ Long Term Care	**13%**	**12%**	**10%**	**11%**
Other	**11%**	**13%**	**12%**	**12%**

2.3 AREA OF RESPONSIBILITY[17]

Direct Patient Care	**89%**	**90%**	**90%**	**85%**
Medical/Surgical	18	18	20	17
Geriatric	14	13	10	11
Home Care	7	4	5	4
Critical care	8	7	7	7
Community Health	7	8	6	6
Emergency care	4	5	5	5
Operating room	4	5	5	4
Maternal/newborn	5	6	6	5

Pediatric	3	3	4	2
Psychiatric/mental health	2	3	4	5
Several clinical areas	9	7	6	6
All other	8	11	12	13
Administration	**6%**	**6%**	**4%**	**7%**
Education	**3%**	**3%**	**4%**	**3%**
Research	**0.6%**	**1%**	**1%**	**1%**

2.4 Employed in the Health Sector[3]

(incomplete data, 79% overall response rate)

General nursing	**FTE**	**FTE/1000**
urban	2936.2	6.54
rural	1925.8	3.38
Primary care nursing		
urban	14	.031
rural	53.5	.093

2.5 RNs and RPNs Employed by Health Districts in Mental Heath[7]

	FTE	**Percent of Total**
Urban	173	57
Regina	76.4	25
Saskatoon	96.6	32
Rural	130.2	43
East Central	26.7	9
Prince Albert	35.8	12
Battlefords	21	7
Moose Jaw/TC	21.8	7
South Central	14.4	5
Swift Current	10.5	3
Total	303.2	100

3. WORKING CONDITIONS

3.1 Vacancy Rate in the Health Sector[3]

	2000	1995-99 average	1990-94 average
General & Specialized			
Urban	4%		
Rural	5%		
Overall	4.4%	1.9%	1.1%

	2000	1996-99 average
Primary care		
Urban	0	
Rural	18.8%	
Overall	14.1%	10.6%

3.2 Turnover Rate in the Health Sector[3]

General & Specialized	
Urban	3.9%
Rural	5.9%
Overall	4.7%

3.3 Wages and Salaries

		Other Jurisdictions		
	Saskatchewan	MB	AB	BC
General duty RPN and RN[37]				
Minimum hourly wage	$23.00	22.02	24.70	24.70
Maximum hourly wage	$27.62	25.96	32.42	32.42
Contract expiry date	03/31/05		03/31/03	03/31/04

* Rates are for 2002-03, as of March 31, 2002; Saskatchewan rates are for the Collective Bargaining Agreement reached by SUN and SAHO in April, 2002

4. EDUCATION AND TRAINING PROGRAMS

4.1 Nursing Education Program of Saskatchewan[16]

(program implemented in 1996)

	2001	2000	1999	1998	1997	1996
Number of applicants	750	750	633	368	299	345
Number of students admitted	271	264	271	216	192	201
Number of graduates						
Diploma		3	14			
Degree	162	98	60			
Number of graduates who successfully wrote the licensing exam for SRNA		123	12			
Proportion of graduates who took positions in Saskatchewan health districts[36]		74%				

4.2 Post Registration BSN Program[16]

	2000	1999	1998	1997	1996	TOTAL
Number of students admitted	30	25	50	70	30	205
Number of graduates	23	24	42	37	30	156

Follow up of graduates

About half report a change in their employment following completion of the BSN, including new employment as educators, community nurses, and managers.

4.3 Masters Program, College of Nursing, U of S[20]

Number of applicants	10-20 annually
Number of students admitted	6-10 annually
Number of graduates	5-8 annually

Follow up of graduates

> It is estimated (based on a sample of 55% of graduates) that about 50% are employed in teaching positions, 40% in administrative positions, and 10% are practicing as Clinical Nurse Specialists.

Nursing Division, SIAST, Wascana, Nursing Re-entry Program

Nursing Division, SIAST, Wascana, Primary Care/Nurse Practitioner Program, Advanced Certificate (Distance)

Nursing Division, SIAST, Wascana, Gerontological Nursing Program, Advanced Certificate

4.8 Education Level of Employed RNs[17]

		Other Jurisdictions		
	SK	**MB**	**AB**	**BC**
Diploma	78%	77%	67%	76%
Baccalaureate	21%	22%	31%	23%
Masters & Doctoral degrees	0.8%	1.7%	2.3%	1.6%

Appendix 5

PROFILE OF SASKATCHEWAN LICENSED PRACTICAL NURSES

1. DEMOGRAPHICS

1.1 Number of LPNs

	Saskatchewan[21]					Other Jurisdictions MB	AB[12]	CAN
	2000	**1999**	**1998**	**1997**	**1990**	**2000**	**2000**	**2000**
All LPNs	2046			1998	2550		4500	
Ratio of LPN population	1/498			1/510	1/400		1/669	

1.2 Location[21]

	No.	%	Ratio of LPN to population
Urban	801	39	1/561
Regina	455	22	1/465
Saskatoon	346	17	1/686
Rural	1223	60	1/466
Assiniboine Valley	41	2	1/392
Athabasca	2	0.1	
Battlefords	69	3.3	1/404
Central Plains	43	2.1	1/483
East Central	90	4.4	1/332
Gabriel Springs	13	0.6	1/919
Greenhead	25	1.2	1/597
Keewatin	5	0.2	1/2186
Living Sky	29	1.4	1/473
Lloydminster	56	2.7	1/193
Mamawetan	22	1.1	1/926
Midwest	50	2.4	1/354
Moose Jaw/TC	107	5.2	1/423

Sources for all data referenced by footnotes are in Appendix 9

Moose Mountain	19	0.9	1/673
North Central	28	1.4	1/432
North Valley	31	1.5	1/464
North-East	26	1.3	1/611
Northwest	24	1.2	1/626
Parkland	43	2.1	1/475
Pasquia	46	2.2	1/366
Pipestone	33	1.6	1/585
Prairie West	29	1.4	1/499
Prince Albert	121	5.9	1/465
Rolling Hills	21	1.0	1/521
South Central	29	1.4	1/676
South Country	25	1.2	1/460
Southeast	52	2.5	1/465
Southwest	14	0.7	1/1059
Swift Current	66	3.2	1/307
Touchwood Qu'Appelle	25	1.2	1/591
Twin Rivers	38	1.9	1/439

1.3 Age

	Other jurisdictions		
	MB	AB	CAN
Average age			

Age distribution[21]

Under 25	3%
25-34	13%
35-44	28%
45-54	39%
55+	17%

1.4 Gender[21]

Female	97.2%
Male	2.6%

2. EMPLOYMENT AND PRACTICE AREAS

2.1 Employment Status

	SK[21]	Other jurisdictions MB	AB	CAN
Full-Time	43.6%			
Part-Time & Casual	56.4%			

2.2 Place of Employment[21]

Acute Care	58%
Nursing Home	11%
Rehab	4.7%
Rural Hospital	4.3%
Home Care	3.5%
Extended Care	2.9%
Physician's Office	2.4%
Integrated facility	2.3%
Community Care	2.0%
Public Health	0.4%
Psychiatric Hospital	0.4%
Other/unknown	8%

2.3 Field of Practice[21]

Medical/Surgical	25.1%
Rural Hospital	20.9%
Geriatric	16.4%
Other care	8.2%
Urban Hospital	7.3%
Community care	4.4%
OR technician	3.4%
Maternal/newborn	2.9%
Paediatric	2.5%
Psychiatric	1.1%
Other	8.0%

2.4 Employed in the Health Sector[3]

(incomplete data, 79% overall response rate)

	FTE	FTE/1000
Urban	618	1.38
Rural	589.8	1.03

2.5 LPNs Employed by Health Districts in Mental Heath[7]

	FTE	**Percent of Total**
Urban	13.1	38
Regina	8.4	24
Saskatoon	4.7	14

Rural	21.5	62
East Central	7.5	22
Prince Albert	14	40
Battlefords	0	
Moose Jaw/TC	0	
South Central	0	
Swift Current	0	
Total	34.6	100

3. WORKING CONDITIONS

3.1 Vacancy Rate in the Health Sector[3]

	2000	1995-99 average	1990-94 average
Urban	4.3%		
Rural	1.9%		
Overall	3%	1.4%	0.4%

3.2 Turnover Rate[3] in the Health Sector

Urban	4.4%
Rural	3.4%
Overall	3.9%

3.3 Wages and Salaries[37]

		Other Jurisdictions		
	Saskatchewan	**MB**	**AB**	**BC**
2002-03*				
Minimum hourly wage	$15.23			22.17
Maximum hourly wage	$16.18			22.58
2001-02*				
Minimum hourly wage	$14.79	15.66	14.57	20.83
Maximum hourly wage	$15.71	19.15	17.63	21.84

* Rates are as of March 31 for each fiscal year.

4. EDUCATION AND TRAINING PROGRAMS

4.1 Nursing Division, SIAST, Wascana, Practical Nursing Program, Wascana, Woodland, and Nursing Division partners at Regional Colleges and DTI[15]

	2002 (projected)	2001	2000	1999	1998	1997
Funded seats*	174	174	102(?)	60(?)	60(?)	40(?)
Enrollments in year 1		?	102	67	46	44
Number of graduates, Certificates	72	86(?)	86(?)	64(?)	41	59

Follow up of graduates	2001	2000	1998	1997	1996	1995
Remained in province	62 (72%)	96%	100%	94%	100%	
Left the province	24 (28%)	16%	4%		6%	

* Numbers for funded seats are for the 18 months needed to complete the program. Annual numbers of students enrolled are lower.

4.2 Nursing Division, SIAST, Wascana, Practical Nursing Re-entry Program, Certificate (Distance)

4.3 Nursing Division, SIAST, Wascana, Home-Based Nursing/LPN Program, Advanced Certificate

4.4 Education Level of LPNs[21]

Certificate, LPN	83%
Diploma, RN	3%
Diploma, RPN	1%
Ex student nurse	3%
Other/unknown	9%

Appendix 6

PROFILE OF SASKATCHEWAN FAMILY PHYSICIANS

1. DEMOGRAPHICS

	Saskatchewan					Other Jurisdictions		
						MB	AB	CAN
1.1 Number	**2000**	**1999**	**1998**	**1997**	**1996**	**2000**	**2000**	**2000**
Total[1]	978					1139	2730	29,936
General Practice	747					767	1360	17,455
Family Medicine	231					372	1370	12,481
Total Number Practicing[2]	932	944	896	868	878			
Ratio of GPs to population[2]	1/1095							

Number of GPs per 100,000 population[2]	**2000**	**1999**	**1998**	**1997**	**1996**	**Percent Change 1996-2000**
SK	91	92	87	85	86	+6.1
MB	92	91	89	88	87	+6
AB	86	88	86	83	85	+1
CAN	94	94	94	93	95	+0.3

1.2 Location

Location of GPs by Health Districts[3]

	Number	**FTE/1000**
Urban	493	1.1
Regina	236	1.1
Saskatoon	257	1.1

Sources for all data referenced by footnotes are in Appendix 9

Rural	427	0.7
Assiniboine Valley	13	0.8
Athabasca		
Battlefords	20	0.7
Central Plains	13	0.6
East Central	20	0.7
Gabriel Springs	7	0.6
Greenhead	7	0.5
Keewatin	9	0.8
Living Sky	11	0.8
Lloydminster	28	2.6
Mamawetan/Churcill River	17	0.8
Midwest	10	0.6
Moose Jaw/Thunder Creek	39	0.9
Moose Mountain	10	0.8
North Central	12	1.0
North Valley	13	0.9
North-East	15	0.9
Northwest	12	0.8
Parkland	29	1.4
Pasquia	13	0.8
Pipestone	14	0.7
Prairie West	9	0.6
Prince Albert	54	1.0
Rolling Hills	6	0.5
South Central	17	0.9
South Country	8	0.7
Southeast	17	0.7
Southwest	10	0.7
Swift Current	18	0.9
Touchwood Qu'Appelle	9	0.6
Twin Rivers	9	0.5
Total	920	0.9

1.3 Age

	SK	Other jurisdictions MB	AB	CAN
Average age[2]	47.4	45.4	45.8	46.2
Age distribution[1]				
Under 35	14.5%			
35-44	31.8%			
45-54	23.8%			
55+	29.9%			
Unknown	1.9%			

1.3 Gender[2]

	SK	MB	AB	CAN
Female	25%	29%	34%	34%
Male	75%	71%	66%	66%

1.4 Foreign Trained GPs[2]

Proportion of GPs whose MD is from a Foreign country	SK	MB	AB	CAN
	60%	41%	31%	22%

Proportional distribution by various regions of MD degree for all physicians (GPs and all specialists)

	Canada	UK/ Ireland	Asia	South Africa	India	Africa	U.S.	All other Foreign
SK	.479	.12	.07	.16	.08	.02	.003	.07
CAN	.768	.07	.03	.025	.02	.006	.008	.07

2. PRACTICE

2.1 Practice Settings

Proportion of GPs in various practice settings
(48% practiced in two or more settings)

	SK & MB 1997[5]	CAN 2001[4]
Private office/clinic	76%	78%
Hospital in-patient unit	31%	35%
Nursing home	26%	24%
Emergency department	28%	25%
Community clinic/health centre	13%	12%
Free-standing walk-in clinic	11%	19%
Academic centre	6%	6%
Other	15%	

2.2 Health Services Provided

Proportion of GPs who offer service	SK & MB 1997[5]	CAN 2001[4]
Mental Health services		
Mental health/psychotherapy		79%
Psychotherapy/counseling	85%	
Other mental health care (e.g., assessment, prescribing psychotropic drugs)	76%	
Preventive medical services/ Lifestyle counseling	77%	80%
Addiction medicine/ substance abuse	66%	40%
Medical services		
Adult health care	89%	
Care of elderly	90%	
Child health care	85%	
Aboriginal health care	77%	
Chronic disease management	80%	85%
Palliative care	70%	69%
Emergency medicine	71%	
Obstetrical care	67%	
Minor surgery	77%	
Major surgery	34%	2%

2.3 Physician Services for Mental Health Reason (1999-2000)[6]

	Saskatoon	Regina	Rural	Total
Billed by GPs	92,776	63,704	200,547	357,027
Billed by Psychiatrists	82,284	26,887	46,037	155,208
Billed by other Specialists	3231	1696	4008	9015
Total	178,291	92,287	250,592	521,250

GPs provide 68% of all physician services for mental health reason; 80% of physician services for mental health reason in rural Saskatchewan, 69% in Regina, and 52% in Saskatoon.

3. Working Conditions[4]

3.1 Some comparisons

	SK	MB	AB	CAN
Percent who provide on-call services	86	75	86	73
Regularly scheduled weekly work hours	60	58	56	53
On-call weekly work hours	24	30	24	20
Total weekly work hours	84	87	80	73
Percent who have reduced their work hours	16	16	25	21

Percent who have increased their work hours	12	12	12	15
Percent not accepting new patients	2	8	6	7
Percent planning changes that would affect the supply of GPs (one or more of leaving Canada, leaving the province, taking temporary leave, change or retraining, retiring)	35	25	19	18

3.2 Outmigration of GPs 1996-2000[2]

	SK	**MB**	**AB**
GPs who moved inter-provincially	199	162	207
Net outmigration Abroad	63	64	113
Net interprovincial migration of All physicians (GPs & Specialists)	-184	-146	+116

4. FEES FOR SERVICES

Fees for counseling/psychotherapy	**SK**	
15 minutes (40B)	$22.00	
60 minutes (41B)	$88.00	
60 minutes (E)	$94.20	(for specially designated GPs billing exclusively for psychotherapy)

5. EDUCATION AND TRAINING PROGRAMS

5.1 College of Medicine, U of S

Proportion of graduates who enter family medicine residency training
Quality of education and training in primary care/family practice

5.2 College of Medicine, U of S, Family Medicine Residency Program[8]

	2001	**2000**	**1999**	**1998**	**1997**	**1996**
Number of applicants	not available					
Number of residents admitted						
Number of graduates						
Proportion of graduates who enter practice in the province						

Appendix 7

PROFILE OF SASKATCHEWAN SOCIAL WORKERS

1. DEMOGRAPHICS

1.1 Number of social workers	2000[22]	Other jurisdictions MB	AB[12]	CAN
SASW (registered)				
Total	975		3760	
Active				

Ratio of social workers To population	SK	MB	AB	CAN
2000	1/1046[22]		1/802[12]	
1997[23]	1/2258	1/2254	1/1781	1/2212
1988[23]	1/4729	1/4424	1/2267	1/2704

1.2 Location[22]

	No.	%	Ratio of employed Social workers to population
Urban	586	60	1/766
Regina	256	26	1/827
Saskatoon	330	34	1/719
Rural	389	40	1/1467
Moose Jaw	30	03	
North Battleford	20	02	
Prince Albert	54	06	
Yorkton	22	02	
Weyburn	15	02	
Swift Current	22	02	
Other	226	23	

Sources for all data referenced by footnotes are in Appendix 9

1.3 Age

Average age[3] (employed in health sector only)	42

	Other jurisdictions		
	MB	AB	CAN

Age distribution (1996) [24]

Under 25	2%
25-34	27%
35-44	31%
45-54	28%
55+	12%

1.4 Gender[22]

Female	79%
Male	21%

1.5 Aboriginal representation in Social Work[24]

		Other Jurisdictions		
Percentage of Aboriginal Social Workers, 1996	SK	MB	AB	CAN
	20%	12%	10%	4.6%

2. EMPLOYMENT

2.1 Place of Employment[22]

	No.	Percent of Total
Health Districts	380	56
Saskatchewan Social Services	66	10
Community Based Organizations	71	10
Saskatchewan Justice	20	03
Government of Canada	6	01
Saskatchewan Education	4	<01
School Social Workers	29	04

Private Practice	83	12
Social Work Education	18	03
Social Work Research	3	<01
Total	680	

2.2 Employed in the Health Sector[3]

(incomplete data, 79% overall response rate)

	FTE	**FTE/1000**
Urban	233.2	.517
Regina	83	.4
Saskatoon	150.2	.6
Rural	139.1	.244
Total	372.3	.365

2.3 Social Workers & Social Service Workers[7] Employed by Health Districts in Mental Heath

	FTE	**Percent of Total**
Urban	44.6	50
Regina	20.5	23
Saskatoon	24.1	27
Rural	45.4	50
East Central	10	11
Prince Albert	6.2	7
Battlefords	8	9
Moose Jaw/TC	8.7	10
South Central	7	8
Swift Current	5.5	6
Total	90	100

3. WORKING CONDITIONS

3.1 Vacancy Rate in the Health Sector[3]

	2000	1995-99 average	1990-94 average
Urban	2.1%		
Rural	2.6%		
Overall	2.3%	3.6%	5.2%

3.2 Turnover Rate in the Health Sector[3]

Urban	2.5%
Rural	5.9%
Overall	3.6%

3.3 Wages and Salaries[38]

			Other Jurisdictions	
	SK	MB	AB	BC
BSW				
Minimum	$21.17	$18.10	$18.99	$23.68
Maximum	$27.82	$23.90	$28.73	$34.15
MSW				
Minimum	$24.15	$20.36	$25.16	$26.39
Maximum	$31.73	$26.96	$38.95	$35.45
Date effective	11/03/02	07/01/02	08/01/01 contract expired	04/01/02

* Assumptions have been made by SAHO on job matches between jurisdictions.

4. EDUCATION AND TRAINING PROGRAMS

4.1 Faculty of Social Work, B.S.W. Program, U of R[25]

	2001	2000	1999	1998	1997	1996
Number of applicants						
Number of students admitted						
Total enrollment			472	693	716	703
Number of graduates				210	217	176
Follow up of graduates						
Percentage of graduates who registered with SASW						

4.2 Faculty of Social Work, M.S.W. Program, U of R[25]

	2001	2000	1999	1998	1997	1996
Number of applicants						
Number of students admitted						
Total enrollment			82	82	82	65
Number of graduates						
Follow up of graduates						
Percentage of graduates who registered with SASW						

4.3 Bachelor of Indian Social Work Program, Saskatchewan Indian Federated College[26]

	2001	2000	1999	1998	1997	1996
Number of applicants						
Number of students admitted						
Total enrollment			210	228	207	197
Number of graduates						
BISW						
Certificate						
Follow up of graduates						
Percentage of graduates who registered with SASW						

4.4 Masters of Aboriginal Social Work Program, Saskatchewan Indian Federated College[26]

	2001
Number of applicants	
Number of students admitted	8
Number of graduates	
Follow up of graduates	
Percentage of graduates who registered with SASW	

Appendix 8

Survey of Mental Health Service Providers in Private Practice

An attempt was made to survey all those (individuals, firms and agencies) providing private mental health services in Saskatchewan. Private services are considered to be those mental health services provided directly to clients for a fee-for-service that is not paid for by public health insurance (Medicare).

All individuals, firms and agencies listed in the Yellow Pages (in Saskatoon, Regina, Prince Albert, Moose Jaw, Estevan, Swift Current, North Battleford, Yorkton) under Counseling, Marriage & Family Counselors, Psychologists, Social Workers, Social Service Organizations, Educational Consultants, and Mediation Services who were considered to be potential providers of mental health services were mailed surveys.

The **distribution of surveys** mailed by location was as follows:

	Saskatoon	**Regina**	**All other cities**	**Total**
Individuals	70	25	23	118
Firms & Agencies	(14)	(15)	(10)	(39)
Estimated total number of individuals employed in firms & agencies[1]	57	52	29	138
Estimated total number of individuals surveyed	127	77	52	256

Overall **response rate** to the survey was as follows:

Estimated number of individuals mailed a survey	256
Number of surveys not delivered and returned by postal service	15
Number of individuals who replied that they did not provide private mental health services	6
Estimated total number of individuals surveyed	235
Number of individuals who returned a completed survey	70
Estimated response rate	30%

[1] In each mailing to a firm or agency, a number of surveys were included based on a rough estimate of the number of individual practitioners associated with the firm or agency.

Survey Results[2]

Please complete the survey if you:

> ***Provide mental health services directly to clients for a fee-for-your services that is not paid for by public health insurance (Medicare).***

Number of respondents 68

Location of private practice

Saskatoon	54%
Regina	28%
Prince Albert	7%
Moose Jaw	6%
Yorkton	1%
Unknown	3%

Age

Average age 48.5 years

Age distribution

Under 25	0
25-34	9%
35-44	25%
45-54	46%
55 +	20%

Gender

Female	54%
Male	46%

Are you a **registered/licensed member of a health/mental health profession?**

No	41%	(9% had applied to be registered in the College of Psychologists; most of the others were members of various fraternal associations of counselors)
Yes		
Social Work	34%	
Psychology	22%	
Nursing	3%	

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[2] Each of the questions asked in the survey is reproduced in reporting these results.

Highest **post-secondary education/training:**

Certificate, Diploma	7%
Bachelors degree	18%
Masters degree	47%
Doctoral degree	28%

Estimate the **time you devote to client services** (including indirect services such as phone calls, writing reports, consultations) in your **private practice:**

Average number of hours per week	25.2 hours

If you also work in the mental health field for an employer(s), please estimate the **time you spend in work for your employer(s):**

No other employment	66%
Part-time employment	25%
Full-time employment	9%

Estimate the proportion of your private practice devoted to the following **mental health services:**

18%	Assessment/diagnosis
67%	Therapy/counseling
15%	Social/community support (assistance with community/family living circumstances, employment, income support, housing)

Estimate the proportion of your private practice devoted to services for the following **clients:**

8%	Children, age 0-10
13 %	Youth, age 11-20
77 %	Adults, age 20-64
2 %	Seniors, age 65 and over

Estimate the proportion of your private practice devoted to services for **clients with the following kinds of disorders/problems:**

1 %	Schizophrenia and other psychotic disorders
1 %	Dementia and other cognitive disorders
13 %	Mood disorders (depression, bipolar disorders)
10 %	Anxiety disorders
5 %	Substance-related disorders
1 %	Eating disorders
2 %	Impulse control disorders (ADHD, conduct disorders, antisocial)
11 %	Adjustment disorders (stress)
29 %	Marital and family problems
6 %	Infancy, childhood or adolescent disorders
15 %	Abuse-related problems (physical, sexual, emotional)
3 %	Other (rehabilitation/health, chronic pain, forensic, loss and grief, custody and access, mediation, gambling, religious/spiritual problems)

Estimate your **gross annual income** from private practice:

Average	$47,451.00	(51 respondents, 17 did not respond to the question)

What **fee-for-service** do you normally charge for the following kinds of client services:

$74.00 /hour	average fee for therapy/counseling and assessments (61 respondents, 7 did not respond to the question)

Estimate the proportion of your income from private practice that is **paid for by the following payers:**

21 %	Saskatchewan Government Departments/agencies (Social Services, SGI, WCB, PSC, Justice, SPMC, SK Power, SK Tel)
9 %	Federal Government Departments/agencies, (MSB/First Nations Health, RCMP, DND, CSC, Health, HRDC)
32 %	Client private insurance plans (EAP, extended health plans)
3 %	First Nations/Métis Nation bands/organizations
27 %	Client, out-of-pocket
2 %	Other (private companies, United Way, school boards, churches)

Appendix 9

Data Sources for Profiles of Mental Health Professionals

1 Canadian Medical Association, January 2001
2 Canadian Institute for Health Information, Southam Medical Database, 2000
3 2000 Saskatchewan Health Employer Survey Report, Saskatchewan Health
4 National Family Physician Workforce Survey, College of Family Physicians of Canada, 2001
5 Janus Project, College of Family Physicians of Canada, 1997
6 Medical Services and Health Registration Branch, Saskatchewan Health, 1999/2000
7 Saskatchewan Mental Health Program Review, Community Care Branch, Saskatchewan Health, 2001
8 Data provided by the College of Medicine, U of S
9 Information provided by the Saskatchewan Medical Association
10 Psychiatry Human Resource Plan, Province of Saskatchewan, 2001, Report of a committee of stakeholders organized by the Regina and Saskatoon Health Districts
11 Information provided by Manitoba Health
12 Information provided by Alberta Health and Wellness
13 Annual Reports, Registered Psychiatric Nurses Association of Saskatchewan
14 Information provided by Saskatchewan Health
15 Data provided by SIAST
16 Data provided by the Nursing Education Program of Saskatchewan
17 Canadian Institute of Health Information, Supply and Distribution of Nurses in Canada, 2000
18 Information provided by the Saskatchewan Union of Nurses
19 Adapted from CIHI, Supply and Distribution of Nurses in Canada, 2000
20 Information provided by College of Nursing, U of S
21 Data provided by the Saskatchewan Association of Licensed Practical Nurses, 2000
22 Data provided by the Saskatchewan Association of Social Workers
23 Canadian Institute for Health Information, Health personnel in Canada, 1988-97
24 In Critical Demand: Social Work in Canada, Human Resources Development Canada, 1999
25 Information provided by the University of Regina
26 Information provided by the Saskatchewan Indian Federated College
27 Information provided by the Saskatchewan Psychological Association
28 Information provided by the Manitoba Psychological Association
29 Information provided by the College of Alberta Psychologists
30 Information provided by the Transitional Council, College of Psychologists of Saskatchewan
31 Information provided by Department of Psychology, U of S
32 Information provided by Department of Educational Psychology and Special Education, U of S
33 Information provided by Department of Psychology, U of R
34 Information provided by Department of Educational Psychology, U of R
35 Information provided by Department of Clinical Health Psychology, RUH
36 Saskatchewan Health, Action Plan for Saskatchewan Health Care, 2001
37 Information provided by the Health Employers Association of B.C. research department
38 Information provided by Saskatchewan Association of Health Organizations

Appendix 10

Interviews and Meetings with Key Informants

Professional associations and regulatory bodies

Saskatchewan Medical Association, Dr. Barry Scharfstein, Dr. Lisa Stalder
Saskatchewan Registered Nurses Association, Donna Brunskill, Shirley McKay
Registered Psychiatric Nurses Association of Saskatchewan, Linda Rabyi, Joy Johnson, special meeting on education of RPNAS members
Saskatchewan Association of Licensed Practical Nurses, Sandra Tokaruk, Ede Leeson
Saskatchewan College of Psychologists, Dr. Elizabeth Ivanochko, Dr. Laureen Wilson
Saskatchewan Association of Social Workers, Klaus Gruber
Dr. David Keegan, Professor of Psychiatry, College of Medicine, U of S
Saskatchewan Association of Family Physicians, Dr. Stephen Goluboff

Unions

Saskatchewan Union of Nurses, Rosalee Longmore, Beverly Crossman
Health Sciences Association of Saskatchewan, Stan Dimnick

Education and Training Programs

Family Medicine Residency Program, College of Medicine, U of S, Dr. Gill White
Psychiatry Residency Program, College of Medicine, U of S, Dr. David Keegan
Nursing Education Program of Saskatchewan, Dean Beth Horsburgh, Assistant Dean Barbara Smith, Professor Cindy Peterneli-Taylor, two other faculty members (two meetings); Kathy White (SIAST, Wascana); Acting Dean Lois Berry (SIAST, Wascana)
Nursing Education Program of Saskatchewan, Dean Beth Horsburgh, Assistant Dean Barbara Smith and three faculty members, Kathy White (Wascana)
Practical Nursing Program, SIAST, Wascana, Louise Frederick and two faculty members
School of Social Work, U of R, Dean Michael MacLean, Mona Acker
Saskatchewan Indian Federated College, Carrie Bourassa
School of Indian Social Work, SIFC,
Clinical Psychology Graduate Program, U of R, Dr. Mary Hampton, Dr. Thomas Hadjistravopolous
Department of Educational Psychology, U of R, Dr. Norm Kuhns
Clinical Psychology Doctoral Program, U of S, Dr. Carl von Baeyer
Department of Educational Psychology and Special Education, Dr. Vicki Schwean

Consumer and advocacy groups

Canadian Mental Health Association, Saskatchewan Division, Dave Nelson
Saskatchewan Mental Health Coalition, meeting of representatives from 12 groups

Government of Saskatchewan

Health, Community Care Branch, meetings with Bruce McKee, Lorne Sier, Traci Schmekel, Joe Kluger, John Mitchell
Health, Primary Health Care, Stan Rice, Dr. Gil White
Health, Early Childhood Intervention, Kelly Richter
Social Services, Betty West, Community Living Division
Social Services, Richard Hazel, Child and Family Services
Public Service Commission, Employee Assistance Program, Don Stevenson

Mental Health Employers and Programs

Child and Youth Mental Health, Regina Health District, Dr. David Randall
Mental Health, Regina Health District, John Labatt, Lorri Carlson
Mental Health, Moose Jaw/Thunder Creek Health District, Terry Hutchinson
Mental Health, Saskatoon District Health, Greg Drummond
Child and Youth, Mental Health, Dr. Tim Greenough
First Nations and Inuit Branch, Health Canada, Dr. John Elias
Kinship Centre, Regina Health District, Joanne Phillips, Dr. David Randall and three staff

Referent Group of all Stakeholders

Five meetings (January, March, April, June 2002, March 2003)