Registered Psychiatric Nurses Association of Saskatchewan

White Paper
2009

RPN
REGISTERED PSYCHIATRIC NURSES ASSOCIATION OF SASKATCHEWAN
Seeing People Through

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"There are really only eight kinds of people who suffer from issues of mental health. Someone's husband, father, brother or son; someone's mother, daughter, sister or wife."

(Simmie & Nunes, 2001)

Executive Summary

The 2007 Canadian Psychiatric Association President announced to the federal and all provincial Ministers of Heath that, the World Health Organization was forecasting mental illnesses would soon become the leading cause of disability in developed nations. It is not surprising then; mental health problems are predicted to eventually affect nearly every family in Saskatchewan. The sparse numbers of mental health professionals who are licensed to conduct diagnostic services and hold prescriptive authority are few and aging. Saskatchewan currently exceeds the national average for urgent psychiatric care and leads the nation for elective psychiatric referrals. These delays contribute to long–term disability and premature, preventable deaths. Though there is no single blunt instrument to address all of the needs of people affected by mental health problems in Saskatchewan: the Registered Psychiatric Nurses' Association of Saskatchewan believes the time is right for the Saskatchewan government to endorse and allocate funding for the education of Registered Psychiatric Nurse Practitioners (RPNPs).

The Right Honorable Beverley McLachlin, Chief Justice of Canada provided a grim Canadian description during her remarks to the Universities of Alberta and Calgary in 2005 during the Justice Michael O'Byrne Lecture on Law, Medicine, and Ethics when she said,

> The facts are clear; mental health problems are huge and all-too-common. These problems sap our society and our economy. Mental health problems affect people from every walk of life and every social rank and, perhaps more than any other health problem engages the legal system in a host of different ways (p.2).

Mental health problems are old, yet perennially significant in Saskatchewan. The main purpose of developing the Registered Psychiatric Nurse Practitioner (RPNP) category is to improve access to basic primary mental health care at first point of contact and in under-serviced healthcare settings so that quality mental health care is more readily available in Saskatchewan. Most importantly however, is that decreasing wait times by increasing access to appropriate mental health services and treatment, increases the potential to reduce disability, avert casualties, and decrease premature deaths. This new paradigm would send the message, 'No one will be left unaccompanied' because the mental health problems of Saskatchewan people are as equally important as physical illnesses. Shifting to a modified model of 'shared care' is a cost-effective solution to address the less than critical mass of psychiatrists who provide diagnostic and prescriptive services, support general practitioners, and offer a realistic retention strategy to lengthen the service-tenure of expert Registered Psychiatric Nurses.

Dan Florizone, the current Deputy Minister of Health was lauded in the *Health Quality Council February 2009 Newsletter* for during his tenure as Chair of the Health Quality Council regularly challenging HQC Board members to consider: 'So, how's the *status quo* working for you?'(p.2).

This *White Paper* provides evidence that the current psychiatric practice *status quo* is not working well instead, is supporting grave disparities for many Saskatchewan people affected by mental health problems compared to those who live with physical illnesses. Because untreated mental health problems will eventually affect all Saskatchewan people, urgent action is needed to ease the wait-times, and reduce deterioration and disability while improving and investing in the recovery of Saskatchewan people. Supporting the Registered Psychiatric Nurse Practitioner as a mental health human resource for the province will be essential to transform the paradigm of 'shared care' for all those Saskatchewan people who are affected by mental health problems.

Preface

Language can promote stigma. The appropriate terminology that best describes people who live with mental illness is widely debated. Terms such as 'consumer', 'patient' and 'survivor' are commonly used in the literature and in clinical practice. Although the term 'mental illness' suggests the individual has received a psychiatric diagnosis from a mental health professional, the term 'mental health problems' includes both diagnosed and undiagnosed people. For the purpose of this paper, the descriptor 'mental health problems' will be used to capture all those Saskatchewan people who live with and cope across the continuum of mental health problems that can appear and re-appear due to diagnosed and undiagnosed psychiatric illnesses.

Issue

Mental health problems are increasingly common in the general population. In fact, few Saskatchewan people will be unaffected by a mental health problem during their life. The province has a scarcity of mental health human resources who have the expertise and the legislative authority to meet the demand for needed psychiatric diagnostic services and prescriptive competencies. The increasing prevalence of mental health problems combined with the scant number of psychiatrists has created excessive wait times, limited access, and treatment delays for people affected by mental health problems in the province.

Challenge

> Stigma and discrimination remain major barriers to mental health. People in Canada, including many health care practitioners, generally have a poor understanding of, and hold negative attitudes about, mental illness. As a result, stigma towards mental illness persists both at the societal and health practitioner level. People without mental illness often discriminate against those who experience it. For many living with a mental illness, this discrimination constitutes a major impediment to their recovery. People with mental illness also experience self-stigma and, as a result, often do not seek diagnosis or treatment. Delays in treatment unnecessarily prolong suffering. (CAMIMH, 2006, p. 4).

Social supports, relationships, social status, personal health practices, health services, medication use, physical health and environmental conditions – these are the determinants of mental health (RPNC, 2005) that can no longer afford to be neglected for they affect how Saskatchewan people work, play, and love, every day.

Saskatchewan Registered Psychiatric Nurses have witnessed improvements in treatment, and philosophies of integration and recovery that have encouraged more people with mental health problems to live in the community; unfortunately, these systems have increasingly reduced numbers of long-term psychiatric beds and neglected to proportionately expand community supports for the growing population living with these problems outside institutions (Horwitz, Kerker, Owens, & Zigler, 2000; Adelman, 2003). Unmet health care needs seem an unintended consequence of the deinstitutionalization process. Once these people were mainstreamed into the community, not all their health care needs were adequately addressed due to a limited availability of community resources and a lack of access to both knowledgeable care providers and a continuum of care (Horwitz et al, 2000). Recent Canadian patient safety literature in mental health reveals a significant proportion of psychotropic medication prescribed by physicians who are not psychiatrists and thus are less familiar with these medicines. These medications have a wider range of adverse effects than most other prescription drugs and account for the majority of medication-related hospitalizations (Bricknell, Nicholls, Procyshyn, McLean, Dempster, Lavoie, Sahlstrom, Tomita & Wang, 2009). Lack of comprehensive mental health services including beds for acute, intermediate, and tertiary psychiatric care creates problems so frequently beds in jails and prisons are used to fill this need (Martin, 2009, NAMI, 2008).

Beyond the prevalence of mental health problems, there are environmental determinants that can significantly affect the capacity of children and families to achieve general well-being (Children's Advocate, 2008). North American sociologists have argued that once 40% of a neighborhood's population falls below the poverty line; the entire neighborhood becomes distressed and increases the risk of endangering the health of the entire community (Vibrant Communities, 2005). Social factors such as poverty, lack of safe housing and employment, social stigma and isolation increases the risk that this population struggles to have basic necessities to live and are less likely to thrive (Carr & Rabyj, 2003, Flórez -Arboleda, 2005, Rabyj &

Kemp, 2009). The inadequacy of income support programs creates significant additional stress on people living with serious mental health problems and in some cases, has resulted in criminal activity that ends in criminalization of this population (Rabyj & Kemp, 2009). Research reveals people with mental health problems are at two and a half times greater risk for victimization than the general population; they are more likely to be violently assaulted with the women at greater risk for sexual victimization and men frequently being victims of robbery or assault (Hiday, Swartz, Swanson, Borum, & Wagner, 1999; Marley & Buila 2001; Silver, 2002).

Canada has historically educated fewer physicians than what is needed to meet its population needs. Not only is Canadian undergraduate medical education capacity inadequate, but postgraduate medical training capacity is similarly insufficient to meet the demands of training Canadian medical graduates, providing training to International Medical Graduates, and permitting Canadians to retrain in specialties (Canadian Medical Association, 2006, p. 2).This might help to explain the small number of psychiatrists in Canada and the fact that approximately 1.7 million Canadians reported in 2007 that they had searched for, but were unable to find, a regular physician to provide their medical care (Canadian Institute for Health Information, 2008, p. 27). Most family physicians complain they are unable to access a psychiatric consult due to excessive wait times for outpatient psychiatric consults and these physicians then over-use emergency departments so that their patients can gain access to psychiatric care (Burley, 2002, p.29)

It has long been recognized that there are significant health human resource challenges in the mental health system, with particular gaps in remote and rural areas (Leitch, 2007). Accessing pediatric mental health services has been historically complex, confusing and frustrating for parents, patients, and professionals; yet, appropriate and accessible community mental health resources are important for the recovery of children and youth (Leitch, 2007). Twelve deaths of Saskatchewan children were investigated in 2007 and revealed that self-harm, lack of resources for severe mental health problems, repeated exposure to family violence, and parental addictions contributed to their demise (Children's Advocate, 2008). These investigation results emphasized the critical need for quality mental health services that includes integrated case management, appropriate and timely assessment and interventions to eliminate preventable deaths of children and youth in the province (Children's Advocate, 2008).

Context

Though there seem to be a variety of models of healthcare delivery operating in the various health regions in the province, the 'shared care' model has been used successfully in mental health care. The expression 'shared mental health care' first appeared in Canadian print in 1997 when a National Task Force on Shared Mental Health Care published a report in *The Canadian Journal of Psychiatry* and in *Family Physician*, the national journal of the Canadian College of Family Physicians. This National Task Force continues to fund and promote dialogue, policy and research on 'shared care' (Burley, 2004).

A Canadian psychiatrist, Katz (2002) defined 'shared care' as diverse disciplines collaborating to share the responsibility of care by pooling their resources so that the necessary services are appropriate and accessible. This 'shared care' paradigm promotes continuity of care while increasing intersectoral and interdisciplinary communication and mutual support so that people get the right care, at the right time, by the right care providers, in the right setting (CIHI, 2008). Shared care aspires to build the health system capacity and deal with the shortage of resources. Mental health problems frequently appear in provincial primary care settings. Clatney, McDonald & Shah (2008) discovered that Saskatchewan family physicians are disappointed with the quality of mental health care they are able to provide and recommended strengthening 'shared care' models between family physicians and mental health professionals to improve diagnosis and management of mental health problems. The critical element to improving the delivery of Saskatchewan mental health services in primary care was identified as improved access to mental health professionals (Clatney et al, 2008).

The Health Quality Council (HQC) supported 'shared care' for mental health in a January 22, 2004 press release wherein results of research conducted by the former Health Services Utilization and Research Commission (HSURC) using 40 studies of 'shared mental health care' were reviewed. HQC (2004) revealed that patients who receive collaborative treatment have fewer symptoms than people receiving traditional care from family doctors, are more likely to have recovered or be in remission at follow-up and besides being more effective than the typical form of mental health care provided by family physicians, 'shared mental health care' is

also preferred by patients. The current Saskatchewan government is open to shifting how shared care is used and changing legislation to support particular populations in the province to gain access to general health care. For an example, see Appendix A.

Mental health problems do not discriminate; they can affect anyone (CIHI, 2008).The then Canadian Psychiatric Association (CPA) President forwarded a letter to the federal and all provincial Ministers of Health in 2007 requesting that wait times for mental health problems be given first consideration, ahead of the wait time strategies in all provinces. The World Health Organization was forecasting mental illnesses would become the leading cause of disability and emphasized that patients affected by mental health problems had not received a comparable level of support and attention as patients with similarly severe medical conditions.

Researchers for the Fraser Institute validated the CPA assertions when their 2008 data suggested,

"that patients seeking mental health treatment are likely to be disappointed with their access to it. With waiting times exceeding four months from a general practitioner to treatment, and with wait times from a meeting with a specialist to treatment that are nearly 170 percent longer than specialists feel is appropriate, it is clear that a great many patients in need of psychiatric attention are facing the effects of rationing in our health care system and experiencing a deterioration of their condition before they get the care they need" (p. 125).

Even though there is evidence that Saskatchewan waiting times for treatment of mental health problems decreased by 10% from 2007 to 2008, Saskatchewan currently exceeds the national average of 1.8 weeks for urgent care and leads the nation for elective psychiatric referrals at 18 weeks compared to the national average of 7.9 weeks (Esmail, Hazel & Walker,, 2008). Family physicians are well aware of the challenges in the Canadian health systems including; long wait times, overcrowded emergency rooms, physician shortages and a frustrated public. These physicians regularly encounter what seem like unsolvable problems that could be improved through collaboration with other health professionals (Wilson, 2008).

Saskatchewan is currently experiencing an economic boom with a demographic bust as the provincial population rises above one million

residents (SIAST, 2008). Despite the population growth in the province, the number of psychiatrists remains small. There were a total of 40 psychiatrists practicing in Saskatchewan in 2007 - 2008, 10 of these psychiatrists were aged 65 years or older (Medical Services Branch, 2008). Many of these psychiatrists who collaborate with medical students and family physicians are expected to be available for on-call shifts in addition to their other professional responsibilities. Wait times for assessment and treatment from these seemingly over-extended psychiatrists is significant as public access to their expertise requires a referral from a general practitioner physician. The former Health Services Utilization and Research Commission released information about the province included in Appendix B that is important to consider.

Trends

Mental health problems are the collective responsibility of a society, not merely an individual concern (World Health Organization, 2004). Despite the estimates that mental health problems will affect 1 in 5 Canadians during their lifespan, our national universal health care coverage is insufficient to address the equity problem that exists for mental health care (Canadian Psychiatric Association, 2007; Steele, Glazier & Lin, 2006). In 2005–2006 just over one-third (35%) of clinic and Emergency Room visits were for mental health and behavioral disorders; statistics show that Canada's homeless tend to use clinics and emergency departments more than any other health service (CIHI, 2008).

Though there is evidence the province is concerned about public access to health care services unfortunately, Saskatchewan has historically allocated a meager amount to mental health problems compared to other areas of health care (Lim, Jacobs, Ohinmaa, Schopflocher & Dewa, 2008). The Children's Advocate (2004) expressed concern about the inequitable distribution of health funds for mental health services in the province creating such tiny resources that Saskatchewan children and youth were repeatedly denied access to timely and appropriate mental health services. This provides an example of how the unlimited coverage of fee-for-service in mental health care, fails to address the marked socioeconomic disparities in service uses (Steele et al, 2006).

Despite WHO's (2004) recognition of the potential to sharpen and 'recalibrate' the functioning and capacity of primary health care systems to transform them into better functioning organizations, this potential has yet to be realized. Mental health problems persist particularly in those populations recognized as most vulnerable including: First Nations, Inuit, Métis peoples, children and youth, women and seniors (Standing Senate Committee on Social Affairs, Science and Technology, 2006). Some of these trends are listed in Appendix C.

Mental health problems occur across the lifespan of Saskatchewan people yet are difficult to capture in terms of economic cost to the province. In 2008, Bill Wilkerson, the Co-founder, Chairman, and CEO of the Global Business and Economic Roundtable on Addiction and Mental Health, highlighted some risks of not making these problems a priority. Mr. Wilkerson's remarks certainly apply to the people of Saskatchewan as will the consequences of minimizing the depth and breadth of our provincial mental health problems:

- Mental illness is not just a mood disorder like depression – it is a heart problem like depression. Mental illness is not just an anxiety problem, it is a breathing problem, a blood problem, it suppresses our immune system and amplifies chronic pain. That's a lot more than a bad mood, or worrying too much. We trivialize depression when we call it a mood disorder. That's like saying a heart attack is just a chest pain. In fact, depression and heart disease are linked (p.6)
- About one in four Canadians who need mental health care actually get it and only 24 percent of those receive evidence-based, guideline-concordant medically necessary (physician) care, according to the past president of the Canadian Psychiatric Association, Dr. Don Milliken of Vancouver (p.4).
- Among those Canadians recovering from one heart attack, depression increases by 500 percent the risks of a second heart attack inside six months of the first that proves fatal (p.6).
- Studies have shown that anywhere from 20 percent to 50 percent of the population with cardiovascular disease suffer from depression (p.6).
- Researchers at Johns Hopkins University recently discovered that by treating depression, we may be preventing stroke (p. 8).

The care for Canadians under the age of 19 seems not to be exceptional, for children and youth are likely to have a serious mental disorder that affects their development and ability to participate in common adolescent activities (Ministry of Children and Family Development, 2003). This is not surprising as Conway (2003) reported that Saskatchewan has an extreme shortage of clinicians and researchers who are trained and practice in the area of child and adolescent mental health. Last year, accessibility to services was identified as continuing to be a problem, particularly for children and adolescents who require services in rural and remote districts by the Children's Advocate. Their report admitted to not even beginning to address the badly needed improvements in determinants of health for First Nations children and adolescents in our province (Children's Advocate, 2008). It is estimated that 70 percent of childhood cases of mental health problems can be solved through early diagnosis and interventions. Early interventions can help these children and youth to lead normal productive healthy lives and save the costs that would otherwise be incurred by providing them with social services throughout their adult lives (Leitch, 2007, p. 130). Early intervention requires immediate access to services so the human resource capacity of the mental health systems must be increased. This sentiment was echoed in the 2004 Children's Advocate Report recommending the training, recruitment and retention of qualified mental health professionals while making resources for child and adolescent mental health services a higher priority in the provincial health care system.

Saskatchewan is home to nine prisons, two forensic hospitals and two healing centers which house adult offender populations who have committed crimes usually while living in provincial or Canadian communities. There are also open and closed-custody facilities and community-based agencies that serve adult and young offenders in the province. There is a disproportionate representation of Aboriginal people held in these agencies. Many of these inmates are re-integrated back into Saskatchewan communities once they are released from custody. A synopsis of the health, psychosocial and shifting states of mental health of many offenders who return to live in Saskatchewan communities reported by Correctional Services of Canada is included in Appendix D.

History

The profession of Psychiatric Nursing, conceived to 'share the care' with physicians, was founded in Hanwell England in the 1840s, by Dr. John Conolly, a British psychiatrist, who is renowned for pioneering the treatment of people with mental health problems without using mechanical restraint. Dr. Conolly referred to the psychiatric nurses of his time as his 'best medicines' (Beauregard, 1976). Saskatchewan began educating Psychiatric Nurses in 1932 and in 1948 legally recognized this distinct profession with the proclamation of the *Registered Psychiatric Nurses' Act*.

Though Registered Psychiatric Nurses (RPNs) are concerned with general health, their expertise and interest is primarily in the area of mental and developmental health and disorders (RPNC, 2005). Registered Psychiatric Nurses first began practicing with vulnerable populations in settings that might have seemed less attractive to other health disciplines and viewed as less prestigious than general hospitals due to the small town locations of the psychiatric hospitals and poorly designed buildings which were often overcrowded and understaffed (Kahan, 1973). All of these factors contributed to adverse public attitudes and stigma about this population and their professional mental healthcare providers that has yet to be eradicated.

During World War II, there were severe staffing shortages in psychiatric hospitals in the province so people affected by mental health problems and developmental disorders were institutionalized together (Kahan, 1973). This resulted in institutional overcrowding and drew public criticism. The post World War II has been described as a halcyon period when a new era of community care began. Dr. F. S. Lawson joined the Psychiatric Services Branch in 1947, and like the British psychiatrist, Dr. John Conolly, offered support to promote the development of the first Psychiatric Nursing curriculum that was modeled after the British plan (Kahan, 1973).

Saskatchewan developed mental institutions by 1957 that boasted a higher percentage of trained ward personnel than any other public psychiatric services in either the USA or Canada. (Kahan, 1973). Care and treatment of people affected by mental health problems began to change dramatically in the early 1960s and a trend toward decentralization of psychiatry developed by 1964. Professionals and the public began to insist upon better facilities for patients and staff and the Psychiatric Nursing Program curriculum was

enriched with an additional course requirement on alcoholism (Kahan, 1973). As reintegrating long-institutionalized patients into the community began, so did the demand for RPNs to assume roles of group therapists and there was an increasing need for Community Mental Health Nurses. Deinstitutionalization of people affected by developmental disorders began later in the 1970s. Chief Justice Emmett Hall chaired the Royal Commission on Health Services in 1966. The Hall Report emphasized the importance of community psychiatry and the education of psychiatric nurses that included recommendations for the provision of bursaries or fellowships to prepare psychiatric nurses for advanced positions in psychiatric nursing (Kahan, 1973).

Employment rates in the 1990's for Registered Psychiatric Nursing graduates was 97%, with 91% of these RPNs staying in the province to render services to Saskatchewan people. Registered Psychiatric Nurses have shown a long history of demonstrating that they are excellent value for the money spent on their education.

The Registered Psychiatric Nurses Association of Saskatchewan (RPNAS) describes in the *2009 Annual Report* that there are: 875 RPNs practicing members in the province; the majority of these RPNs are between the ages of 46 – 50 years of age; 15% of these members are male; and although 91% of the RPNs in the province practice in diverse areas of direct care primarily, RPNs in Saskatchewan are employed in hospitals, personal and long term care, and community mental health settings (RPNAS, 2009).

Today, Canadian Registered Psychiatric Nurses are employed in diverse areas of practice, education, administration and research (RPNC, 2005). Registered Psychiatric Nurses are not unique to Canada. RPNs also practice in other countries such as Australia, New Zealand, England, Scotland, Ireland, Wales, and Bermuda where their practice is licensed separately from general nurses by Psychiatric Nursing legislation and professional regulatory bodies using Psychiatric Nursing: Standards of Practice, Codes of Ethics and Competencies (RPNC, 2005). Since 1993, the Registered Psychiatric Nurses Association of Saskatchewan has been advocating for a Registered Psychiatric Nurse Practitioner (RPNP) Program for the province.

Internationally, Registered Nurses have had opportunity to gain additional education and become Nurse Practitioners. There are 12 jurisdictions in Canada with Nurse Practitioner (NP) legislation where Registered Nurse

NPs are allowed to perform diagnosis of diseases, disorders or conditions; order and interpret diagnostic and screening tests; and prescribe medication and the Registered Nurse Practitioner legislation in many Canadian jurisdictions enables these NPs to perform other functions as well (Canadian Nurses Association & CIHI, 2006, p.11; Canadian Nurse Practitioner Initiative, 2006). The Canadian Institute for Health Information & CNA (2006) data provided a historical synopsis of Registered Nurses who were practicing as NPs in Canada in 2005:

- Less than 1/3 of these licensed NPs initially graduated from a baccalaureate program in registered nursing and nearly one-third of those licensed in 2005 as NPs first graduated from nursing school before 1980 (p.14).
- 94.5% of licensed Registered Nurse NPs were employed at the time of their license registration in 2005 compared to the overall RN workforce who were employed at a rate of 51 – 54 % in 2005 (p.2).
- 88.7% of licensed NPs in Canada worked in direct care in 2005 (p.16).
- 42.5% of these licensed NPs employed in 2005 worked in the community health sector, with more than one-quarter (26.9%) in the hospital sector (pp.15 -16)
- A mere 1.1 % of Canadian NPs work in areas responsible to provide care to populations requiring either psychiatric or mental health services (pp.15 -16).

According to the Standing Committee on Health Services within the consideration of estimates for the Ministry of Health during the March 30, 2009 televised dialogue, a Nurse Practitioner (NP) Program has been available for Registered Nurses in this province since 1993. This Standing Committee reported there were 109 Registered Nurses practicing in Saskatchewan in December 2008 who use an expanded range of expertise that includes diagnostic and prescriptive practice. These NPs have been a good investment for the province for these nurses began as Registered Nurses in Saskatchewan then, upgraded their competencies to the practitioner level and have remained practicing in the province. Last year, the Saskatchewan Ministry of Health supported these NPs by making $200,000 available in student bursary funding in 2007 – 2008 (MBS, 2008).

The Registered Psychiatric Nurses Association of Saskatchewan invited diverse stakeholders in October, 2008 to share their vision of a new 'shared care' through the use of RPNPs for the province. Stakeholders representatives such as: Saskatchewan Health Unit C Program Support (Alcohol and Drug, Mental Health, High Risk Youth, Project Hope, Safe Driving), the Canadian Mental Health Association, other health regulatory bodies (including the College of Physicians and Surgeons), consumers, psychiatric nursing students et cetera responded to the proposed development of the RPNP in Saskatchewan with overwhelming support and enthusiasm. The dialogue created during and following the presentation validated that the RPNP is a long over-due health human resource in this province. Additional stakeholder consultations with Regional Health Authorities and psychiatrist representatives have echoed consensus support in principle for the RPNP human resource. Interdisciplinary curriculum support and pilot sites for clinical sites have been suggested to the RPNAS.

The needs of people with mental health problems are many. Limited access, limited availability of prescribers and a small number of psychiatrists creates delays for service and treatment. The public wants more emphasis on 'doing' instead of studying and re-studying issues – moving forward with programs for delivery of services needs to be a priority. (Leitch, 2007, p.36).

Solutions & Strategies

Canadians have become accustomed to Nurse Practitioners helping them gain access to timely care for physical illness. The Canadian Nurse Practitioner Initiative was launched in 2004 to construct a framework to encourage full integration of Registered Nurse Practitioners into Canadian health care. Decima Research (2006) revealed strong public support (88%) for the integration of NPs into health care services. Sangster-Gormley (2007) highlight a growing body of research evidence that supports the effectiveness of the Nurse Practitioners' performance that improves access to care reduces length of hospital stays while shrinking system costs and results in satisfied patients. These Nurse Practitioners were reported to appropriately order diagnostic testing, prescribe medications, reduce emergency department visits, spend more time with patients while providing more educational information related to patient self-care, and improve client-care system outcomes (CNA, 2008; Sangster-Gormley, 2007).

There is also increasing international evidence of the importance of psychiatric nurses who have additional educational preparation so that they have diagnostic and prescriptive authority. Snowden (2007) acknowledges that the literature is broadly supportive of mental health nurses prescribing medication to people with mental health problems. Jones (2007*)* described the positive experiences of patients whose medication was prescribed by mental health nurses in a recent qualitative study. Broom, Shirk, Pehrson & Peterson (2008) highlight the invaluable contributions of Psychiatric-Mental Health–Advanced Practice Nurses to the culture of nursing excellence through their work of enhancing clinical practice, building partnerships, teaching, providing leadership and support, researching, and generally transforming their organizations toward a new paradigm for nursing quality where evidence to guide best practice is used to optimize patient outcomes (p. 134). Grando (2005) discussed practice activities of psychiatric nurses who work in primary care at a practitioner level and share prescriptive authority with psychiatrists. Fowler (2006) identified psychiatric mental health nurse practitioners as well positioned to identify and intervene with alcohol dependence and depression (p. 303). This evidence has led to an increasing interest in developing Registered Psychiatric Nurses at the practitioner level. For example, Nurse Practitioner regulations that primarily focus on a clinical role for Registered Psychiatric Nurses practicing in New Zealand have been implemented for almost a decade (Smith, 2008). Given the increasing concern about mental health problems across Canada, the wait times and challenges to access to care, combined with the public support for Nurse Practitioners generally, (Decima Research, 2006) public support for Registered Psychiatric Nurse Practitioners seems reasonable.

Costs & Benefits

It might be argued there are many direct and indirect costs related to mental health problems. The scope of this *White Paper* is limited to highlighting some economic, social and health effects of these problems to emphasize the importance and urgency for the Saskatchewan government to support the obvious need for the RPNP in this province.

Mental health has not yet become a public priority nor has it gained an equal ‘playing field’ with respect to funding compared to other disability groups. The saying, ‘money talks’ can help to explain the economic effect of mental

health problems on society. Mental health problems increasingly contribute to government expenditures. For example, in 2004 – 2005 the total acute inpatient costs in Canada (excluding Quebec) were estimated to have been $17,046.6 million (CIHI, 2008, p. i). There were 12,675 Saskatchewan hospital days used per 100,000 population for mental illness in 2003 - 2004 (CIHI, 2006). Relapse of mental health problems in Canada is a common and costly phenomenon that can be calculated by the rates of re-hospitalization which are very high in comparison to re-admissions for other disorders (CIHI, 2006; CIHI, 2007; Madi, Zhao & Li 2007). For example, hospital re-admission rates in Canada examined for the fiscal years 2003–2004 and 2004–2005 show that after one week, more than four percent of individuals diagnosed with schizophrenia had been re-admitted to hospital for a mental illness, the proportion increased within the first 30 days of follow-up, and then to about 38% after one year (CIHI, 2008).

The cost of providing general health care services is astounding with physician services as the third largest spending item in Canada in 2007 at about $21.5 billion that was 8.5 percent more than in 2006 (CIHI, 2007). Some estimate that mental illnesses alone add to our health care system costs by as much as $7 billion a year, which is second only to cardiovascular disease (Dosanjh, 2005). There is a list of the top 15 most expensive medical conditions in Canada; mental health problems appear twice on this costly roll (CIHI, 2007).

Mental health problems appear in the literature as ‘burdens’ on society due to illness. Research on the economic burden mental health problems create in Canada (Appendix E) demonstrates the mounting costs that have nearly quadrupled in 6 years when a population-based measure was used.

Wilkerson (2008) explained that although mental health problems are part of the human experience, it is important to recognize these problems also create social costs for everyone and their price grows the longer they remain untreated. It is hard to measure the cost of human dignity or the price of competent care for those who live with mental health problems (Wilkerson, 2008). The social costs of mental health problems are many. For example, when people have a limited ability or inability to work, there is an increased risk to create at a minimum financial hardship or at worst, poverty. The percentage of the Canadian population not working due to mental illness in 2003 included:

- Males (20 – 34 years) 14.1%
- Males (35 – 49) 24.7%
- Males (50 – 64) 42.6%
- Females (20 – 34 years) 18.2%
- Females (35 – 39) 23.4%
- Females (50 -64) 51% (Statistics Canada, 2003).

The Alberta Mental Health Board and the Institute of Health Economics (2007) provide data (Appendix F) that verifies everyone loses when employees are affected by mental health problems. Though mental health problems are costly, they have become increasingly difficult to ignore. Appendix G offers an indication of the economic effect of disability as a result of mental health problems in Canada.

Even though Saskatchewan is currently recognized as the 'economic engine' of Canada, it is a well-publicized truth that Saskatchewan is experiencing a shortage of skilled workers while the Canadian workforce is being replaced at only half the rate that people are retiring (SIAST, 2008). The Canadian Council on Learning (2008) expressed an urgency to support Aboriginal students increase their educational preparation. This pressing issue should be of particular interest to this province given the growing rate of Aboriginal residents and the projected need for skilled workers in the province. An analysis of barriers to educating Saskatchewan youth to build this province provides a hint that there is a link to mental health problems when approximately 20 percent of Canadians aged 20 years and over have never completed high school. (CCL, Feb., 2009). Canadian children and youth students are impacted by mental health problems at a rate of approximately 15 percent to such an extent that their healthy development is inhibited (CCL, April, 2009). Mental health problems have begun to appear in a growing body of research about youth and are linked to learning difficulties, school drop - outs, substance abuse, increased risk for suicide and re-occurring symptoms of depression in adulthood (CCL, April, 2009). The Canadian Council on Learning (Feb., 2009) states the cost of dropping out of school has staggering economic and social consequences to society (Appendix H).

The Children's Advocate suspects that mental health services provided through the Regional Health Authorities were provided to only about 10% of the 42,488 children and adolescents in Saskatchewan in 2007, who were

estimated to have a mental health problem (Children's Advocate, 2008). It would be a reasonable estimate then, to expect this economic burden to the province to increase given the predicted trends of mental health problems unless children and youth gain timely access to quality mental health services.

Despite Canada's international reputation for providing universal health care, our nation spends the least amount on mental health of total health expenditures or five percent compared to 12.1 percent in the United Kingdom (Jacobs, Ohinmaa, Dewa, Bland, Block & Slomp, 2008; Department of Health, 2002). Saskatchewan also has yet to make mental health a priority by allocating equitable financial resources from the health budget to address mental health problems. For example, Saskatchewan had the lowest provincial government expenditure of dollars per capita for mental illness during 2003 – 2004 in Canada, spending a paltry $138 that included mental health services for: hospital and outpatient, public pharmaceuticals, physician, community mental health and addictions (Jacobs et al, 2008).The lowest ratio of mental health spending to total health spending by a province in 2003 – 2004 was in Saskatchewan with a 4.4 percent public spending ratio (total public spending divided by all provincial health spending) and a 3.5 percent total spending ratio (total mental health spending from public and private sources divided by the total public and private expenditures) (Jacobs et al, 2008).This small spending did little to change for example, the death rates of people who had mental health problems: Statistics Canada (2005) reported suicide rates per 100,000 population in 2001 in Saskatchewan persisted at 11.3. People in this province are compromised, disabled, and sometimes dying because mental health problems have been actively ignored and mental health services have been chronically under-funded and under-serviced. Consumers of mental health services die an average of 25 years earlier than the general public (Everett, Mahler, Biblin, Ganguli, & Mauer, 2007). Unfortunately, many medical problems of people with mental illnesses go undetected or untreated (Druss, Marcus, Campbell, Cuffel, Harnett, Inoglia, & Mauer, 2008).These inadequate services are partly due to the reality that human resources for mental health problems are often sparse or forgotten. Saskatchewan residents who are affected by mental health problems should no longer be expected to rely on random acts of kindness for social support networks; families and volunteers should no longer be expected to soldier on as service providers with sparse economical or professional resources for support (RPNC, 2005). Sincere efforts have been made by the Saskatchewan

government representatives to partner with the Saskatchewan Medical Association and the College of Medicine to provide numerous recruitment and retention programs to help enhance recruitment and retention efforts that totaled $27.78 million (MSB, 2008) yet, the province continues to lack a critical mass of psychiatrists.

The World Health Organization asserted in 2004 that, "Mental health is more than the absence of mental illness: it is vital to individuals, families and societies" (p. 10). Recent literature measures and describes the importance of an individual's well-being to determine the vitality of their community (Scott, 2009); an individual's well-being can also appear as a reflection of whether a community is truly flourishing (Shah & Marks 2004). Short-term views about mental health problems have begun to convert to more realistic long-term approaches; the urgency to craft imaginative strategies to 'do what is right for the people' needs to be emphasized. RPNs have long partnered with what has been viewed by some as languishing populations, in grass-roots activities to promote mental health and prevent mental health problems all the while, recognizing that these people have potential to flourish if afforded timely and appropriate support and resources. The 'soft skills' or interpersonal, communication and leadership skills of the RPNP that are "coveted by employers" (CCL, 2008, p. 3) will help to bring individuals, groups, families and communities together to promote mental health and prevent mental health problems at a time when public consensus is swelling to expect better for all people in society. From the boardroom to the street, the standard 'us' and 'them' have gradually begun to shift to become 'we' in rural and urban centers.

Registered Nurse Practitioner resources were created in this province so that people would have improved access to care and reduced waiting times for physical health concerns. Wait times and access to quality mental health care in Saskatchewan needs comparable resources using the RPNP. Improving and promoting the mental health of Saskatchewan people is a realistic proposal for Saskatchewan as there is potential to affect many sectors. For example, schools and work places are arenas where RPNPs can support people to be and become the productive citizens who will contribute to the province through their social, civic, and economic involvement (Scott, 2009, Shah & Mark, 2004).

Saskatchewan can no longer afford to continue using the *status quo* approach that supports people with mental health problems to remain downtrodden, demoralized, and marginalized. There is a sector of the population who lives with mental health problems that are chronic, highly debilitating, and are refractory in nature: historically, these problems regularly required long stays in hospital to regain stability. The current health care system offers only brief hospital stays for mental health problems so the incidence of unplanned hospital re-admissions should not be a puzzle. These less than desirable outcomes might be avoided using the RPNP to assess and diagnose so that earlier intervention, increased availability of outpatient and community services is possible sooner to better manage symptoms, stabilize individual situations, reduce relapse, reduce re-admissions, and support recovery. The availability of community care and access to anti-psychotic medications are well recognized as advantages to assist in reducing the likelihood of costly re-admission to hospital for individuals diagnosed with schizophrenia (Lyons, O'Mahoney, Miller, Neme, Kabat, & Miller, 1997; Rabinowitz, Lichtenberg, Kaplan, Mark, Nahon, & Davidson, 2001, p.1). The RPNP would be educated to have additional competencies to assess, diagnose, and prescribe for mental health problems in this population.

In 2007, the Registered Psychiatric Nurses of Saskatchewan developed Standards and Competencies for the RPNP. The document describes standards and competencies that are in addition to the core competencies of an entry-level RPN and includes mental health promotion skills. The RPNP will focus their clinical practice on individuals, groups, families, or populations across the life span at risk for developing or having a diagnosis of a mental health problem and/or developmental disorder then, be involved with continuous promotion of optimal mental health, prevention and treatment of mental disorders and general health maintenance across wide-ranging services including: assessment, diagnosis, treatment and management of mental health problems. These RPNPs will build on their existing knowledge of psychiatric nursing while incorporating additional competencies of psychiatric nursing practice and will be prepared to provide the public with another point of access to mental health care service.

There are many benefits to be realized by the integration of RPNPs into our healthcare system. RPNPs could relieve the pressure and workload of emergency and family physicians by collaboratively reviewing and treating people with mental health problems. This will reduce wait times in the

emergency departments and ease the pressure on overworked family physicians and psychiatrists particularly, in rural and Northern Saskatchewan. RPNPs could also provide care to patients in community settings further enhancing access to mental healthcare in the province.

The RPNAS will play a significant role in promoting the integration of RPNPs into our mental healthcare system. RPNAS expects that RPNPs will improve access, delivery and co-ordination of mental health services to the public. RPNAS is not suggesting that RPNPs take over physicians' duties instead, that they complement the mental healthcare system by working collaboratively with family physicians, psychiatrists and other healthcare providers. Further, RPNAS recognizes that developing the RPNP role does not eliminate the need nor substitute, for increasing the numbers psychiatrists or family physicians in the province.

Funding the RPNP program is important. The province has yet to support an NP Program that includes the necessary depth and breadth of clinical and theoretical knowledge designed to reduce emotional distress, facilitate cognitive and behavioral change, foster hope and self-efficacy, build capacity, and promote resiliency and recovery in populations affected by mental health problems and/or developmental disorders.

This practical strategy would benefit the province by increasing the skills and competencies of RPNs educated at a practitioner level prepared with advanced expertise in mental health promotion, mental health prevention, early intervention and education that educates about and targets the determinants of mental health which will support our provincial health system to allocate resources using an ‘upstream’ approach (McEwan, Waddell, & Barker, 2007). The psychiatric nursing profession holds promise for relieving chronic shortages of licensed mental health providers who have prescriptive and diagnostic privileges that will improve access to and quality of care for a range of mental health needs. The RPNP will be specifically prepared to collaborate to help populations affected by mental health and/or developmental problems. These Registered Psychiatric Nurse Practitioners (RPNPs) would combine: prescriptive authority and familiarity with an ever-changing psycho-pharmacy formulary, with an array of physical and mental health diagnostic, treatment skills, mental health prevention, early intervention, education, mental health promotion, and recovery-based interventions. Given that psychotropic medications are the primary mode used in Canada by psychiatrists to treat mental health problems (Bricknell et

al, 2009), having the legislated authority and competencies to diagnose mental health problems and prescribe will be essential. The RPNP is the ideal mental health professional to help transform the psychiatric practice paradigm and assume a collaborative role to share the care with physicians, especially in rural and Northern Saskatchewan.

The Registered Psychiatric Nurses' Association of Saskatchewan (RPNAS) proposes that Saskatchewan Government representatives promptly direct and fund Saskatchewan Institute of Applied Science and Technology to develop a Psychiatric Nurse Practitioner Program for Registered Psychiatric Nurses in the province using the RPNAS standards and competencies prepared for RPNPs. SIAST has been the primary post-secondary educational institution in the province interested and committed to educating RPNs and has an established record of educating Registered Nurse Practitioners which reported a 71 % employment rate of Primary Care Nurse Practitioner graduates in 2006; 14 % of those graduates rated the overall quality of education program excellent and 57 % evaluated the program as very good (SIAST Graduate Employment Report, 2007). Research for this paper revealed the total cost of tuition for the Registered Nurse Practitioner Program noted in the Wascana Campus Tuition & Fees 2009 – 2010 schedule on the SIAST website to be $7218.75. This program uses a cost recovery formula and offers 15 seats annually to Registered Nurses (Ministry of Advanced Education, Employment and Labour, personal communication, July 20, 2009).

The Registered Psychiatric Nurse Practitioner (RPNP) program would create a career laddering opportunity for experienced diploma prepared RPNs who would require at least 5 recent years of professional clinical practice experience (Benner, 1984) and /or a minimum of 10,000 hours (Ericsson, Charness, Feltovich & Hoffman, 2006; Omahen, 2009) of clinical practice as an RPN within the previous 10 years to qualify for entry into the RPNP program. RPNAS would expect this program to: incorporate technology, to prepare the RPNP for clinical practice within a time frame comparable to what has been historically allocated within the Registered Nurse Practitioner Program at SIAST, and create at least 15 seats for RPNP program seats. Graduates from the RPNP Program would then be prepared with expanded psychiatric nursing expertise that includes diagnostic and prescriptive abilities. Government scholarship/bursary funding support comparable to what has historically been allocated to the Registered Nurse Practitioners, medical residents and midwives would support the recruitment of

experienced RPNs into the RPNP program. Provincial policies and legislation that support the mental health of all Saskatchewan people will need revision to include the RPNP so that mental health promotion, prevention and early intervention can be strengthened to reduce mental health problems.

Given the substantial projected mental health needs and the many declarations of pending health care professional shortages world wide, it is obvious the province will require the use of a variety of healthcare professionals in appropriate roles. RPNAS suggests the introduction of the RPNP is an affordable addition and enhancement to the mental health work force that will increase access and capacity of provincial mental health services. The financial cost - savings to the province due to early and relapse interventions provided by the RPNP will measurably decrease demand for hospital care. Prevention and promotion for mental health problems provided by the RPNP has significant potential to generally contain the cost of the delivery of provincial mental health services long-term. The cost to develop the RPNP program ought to cost the province less than $300,000. A cost-recovery formula might be used to operate the RPNP program so that government bursary funding of approximately $200,000 yearly would be made available to support 15 bursaries for RPNs who register in the program and return service to the province following graduation. These calculations are general estimates comparing available data from provincial expenditures currently applied to the Registered Nurse Practitioner Program.

Registered Psychiatric Nurses are in a privileged position to provide high quality mental health care to the people in the communities where they live and have demonstrated their unwavering commitment to Saskatchewan people affected by mental health problems and developmental disorders since 1948. This should provide a hint of the potential promise and important future contributions the RPNP will make in Saskatchewan health care.

Summary

The aim of transforming the psychiatric nursing practice paradigm is to change the *status quo* and strengthen 'shared care' between physicians and Registered Psychiatric Nurse Practitioners so that Saskatchewan people affected by undiagnosed, diagnosed or severe mental health problems who have historically been under-served and who have little hope, have timely access to appropriate psychiatric care.

Registered Psychiatric Nurses have long known that although good intentions might contribute to progress, authentic advancement in mental health services requires diligent determination and advocacy. The Registered Psychiatric Nurses Association of Saskatchewan respectfully present this *White Paper* as evidence of their firm dedication to advocating for improved access, service, and reduced wait times for Saskatchewan people who live with mental health problems. Registered Psychiatric Nurses have partnered with these Saskatchewan people and their physicians for more than 60 years. Through such partnerships, Registered Psychiatric Nurse Practitioners will continue to work ~ for the people and with the people ~ to advocate with, promote and transform mental health services in Saskatchewan.

The Registered Psychiatric Nurses' Association of Saskatchewan expects that drawing attention to the need for Registered Psychiatric Nurse Practitioners opens a hopeful door to reduce wait times, increase timely access and improve mental health service for Saskatchewan people. Now, Saskatchewan government has an opportunity to ~ stand up and stand out ~ by supporting the creation of the Registered Psychiatric Nurse Practitioner paradigm in this province and reaffirm the World Health Organization (2004) declaration that:

"There is no health without mental health."

Appendix A

The current Saskatchewan government has demonstrated their interest and support in changing health paradigms. For example: *Appendix 4: Regulatory Amendments 2007 – 2008 of* the Province of Saskatchewan - Ministry of Health 2007 – 2008 Annual Report notes:

- *The Midwifery Act* received Royal Assent in 1999 to provide self-regulating authority to the midwifery profession. Sections 8 to 10, sections 18 to 43, sections 47 and 49, were proclaimed on March 14, 2007 received Royal Assent during the 2008-09 fiscal year.
- *The Drug Schedules Amendment Regulations* were amended in 2007 to facilitate the implementation of licensed midwifery services in the province, by authorizing midwives to prescribe, dispense, and administer the necessary drugs to provide care to a woman and her baby (pp. 64 – 65)
- *The Medical Laboratory Licensing Amendment Regulations, 2007* were amended to provide the authority for medical laboratories to perform tests ordered by midwives
- *The Regional Health Services Administration Amendment Regulations, 2007* were amended to allow midwives and nurse practitioners to prescribe as health professionals who may provide health services at a facility operated by the regional health authority or affiliate; and refer patients to health services delivered by the regional health authority or affiliate.
- *The Saskatchewan Medical Care Insurance Payment Amendment Regulations, 2007 (No. 3)* were amended to facilitate the payment of referral fees to general practitioners and specialists when referred to by a licensed midwife.
- *The Hospital Standards Amendment Regulations,* 2007 were amended to facilitate the introduction of midwifery services in Saskatchewan by providing the authority for midwives to:

  - ☐ take medical histories, make diagnoses, and complete health records
  - ☐ complete discharge summaries for patients who have separated (including deceased)
  - ☐ report, diagnose, and dispose of cases
  - ☐ request the disclosure of their patient's health record

- *The Midwifery Amendment Act, 2008* was amended to clarify that Midwives are able and trained to provide post-partum care (approximately 6 weeks after birth) for mother and baby (p.64) *The Attending Health Professionals Regulations* were amended in 2007 to:
    - ☐ allow midwives to admit, attend to and discharge hospital inpatients and register outpatients
    - ☐ allow oral maxillofacial surgeons to admit, attend to and discharge hospital inpatients
    - ☐ allow registered nurses (nurse practitioners) who are not employed by a regional health authority to register, attend to and discharge a hospital outpatient (pp. 64 – 65).

Appendix B

The former Health Services Utilization and Research Commission released data about Saskatchewan demographics in 2002:

- The province has a large seniors' population: 14.6 % of Saskatchewan residents were 65 or older in 2001, compared to 12.6 % of Canadians.

- Saskatchewan Aboriginal population is large (11.4% of our overall population, versus 2.8% across Canada) and young (more than 40% of Saskatchewan's Aboriginal population was under age 15 in 1996, compared to 21% of the province's non-Aboriginal population.

Some sobering facts about Saskatchewan were made public in 2002 by the former Health Services Utilization and Research Commission:

- Life expectancy in Saskatchewan is far below the Canadian average expected in other provinces.
- Between 1994-95 and 2000-01, there was a three-fold increase in unmet health care needs in Saskatchewan.
- Saskatchewan's supply of family physicians is slightly below the national rate and the province has significantly fewer specialists.
- The province's rates of suicide and depression are much higher than Newfoundland and Labrador's (provinces with the lowest rates).
- In 1998-99, mental disorders replaced digestive diseases as the third leading category of hospital days in Saskatchewan.
- Between 1994-95 and 2000-01, probable risk of depression increased in Saskatchewan.

Appendix C

Regrettably, RPNs regularly witness the following trends affecting those Saskatchewan people who are recognized as most vulnerable:

- Health Canada estimates that 4 to 5 million Canadians engage in high risk drinking, which is linked to motor vehicle accidents, Fetal Alcohol Spectrum Disorder, chronic health issues, family problems, crime and violence (Leitch, 2007, p. 39)
- People with depression or bipolar disorder are about twice as likely to be obese as the general population and people with schizophrenia are three times more likely than the general population to become obese. This is in partly due to many psychotropic medications (Torgovnick, 2008).
- Saskatchewan people most commonly abuse alcohol and marijuana and alcohol dependence rate is 4% for people over the age of 15 in the province (Health Canada, 1999)
- Mental health issues affecting children and youth are substantive and can range from the effect of bullying, mental stress over exams and getting into good schools, to psychiatric illnesses such as schizophrenia and bi-polar disorder requiring the intervention of health care services. (Standing Senate Committee on Social Affairs, Science and Technology, 2006).
- Unfortunately, only one in five Canadian children who need mental health services currently receives them (Sun Life, 2006).
- *Saskatchewan Health 2007 – 2008 Annual Report* notes that only 11.8 % of children and youth 19 years of age or younger in the province received services from Mental Health Services in Regional Health Authorities in 2006.
- Youth violence is a substantial public health problem (Hahn, Fuqua-Whitley, Wethington, Lowy, Crosby, Fullilove, Johnson, Liberman, Moscicki, Price, Snyder, Tuma, Cory, Stone, Mukhopadhaya, Chattopadhyay, & Dahlberg, 2007).
- Late-life depression generates tremendous emotional and physical suffering and disability and mortality, compromises quality of life, produces significant clinical and public health costs, and increases suicide risk (Blazer, 2003).

- Families often lose freedom and suffer financially and emotionally because of mental health problems (Northeast Mental Health Task Force, 2002).
- With the aging of the population, a significant increase in age-related mental disorders such as depression appears (Northeast Mental Health Task Force, 2002).
- As a result of technological innovations and other factors associated with increased longevity, individuals with long-standing mental illnesses who have lived successfully in the community will also age; this affects the need and demand for specialized support services (Northeast Mental Health Task Force, 2002).
- The presence of multiple diagnoses or concomitant physical disabilities among some older people lends further complications to planning for, and delivering services to, older individuals with mental health problems (Northeast Mental Health Task Force, 2002).
- Age-related mental illnesses have not always been viewed as mental health problems but rather as problems of old age (geriatrics). The lack of acknowledgement of these mental health problems has been detrimental for it has resulted in uncertainty about who is responsible for serving these individuals (Northeast Mental Health Task Force, 2002)
- People with schizophrenia often expect to be discriminated against, and are, in various aspects of their life according to new research. This population reported 47% discrimination in making or keeping friends, 43% from family members, 27% in intimate or sexual relationships and 29% said they experienced discrimination while trying to find or keep a job. (Canadian Press, 2009)
- People who self-harm may reject help from health professionals and many do not keep appointments. Others may be rejected by health professionals and may not find health services helpful (Boyce, 2004).
- In primary care, 83% of people who have self-harmed have contacted their GP within the previous year, and 20% on the day before their suicide (Boyce, 2004).
- Women are more likely than men to develop posttraumatic stress disorder. The same is true for trauma victims (of both sexes) who believed that their life was in danger (Voges & Romney, 2003).
- Percentage of youth who become prostitutes to earn money for drugs is 44% (Leitch, 2007).

- Percentage of youth prostitutes who do not use alcohol or drugs is 8% (Leitch, 2007).
- Individuals with developmental disorders are now surviving long enough to be at risk for age-associated conditions such as dementia of the Alzheimer type. For example, most adults with Down Syndrome experience a higher rate of dementia and show Alzheimer-like symptoms after 35 than those without Down Syndrome. (Horwitz et al, 2000).
- Autism has been reported in .05% -.17% of children in the general population, in 5% among those with mild developmental disorders, and in 15% among individuals with moderate or profound developmental disorders (Horwitz et al, 2000).
- The effect of depression on individuals with developmental disorders is significant and has been shown to be associated with aggressive behavior, anger, irritability, antisocial behavior and conduct problems (Horwitz et al, 2000).
- Several risk factors shown to be associated with being the victim of stalking include being female, young, and Aboriginal (Dauvergne, 2008).
- More than half (55%) of all victims of family violence were victimized at the hands of a spouse (Statistics Canada, 2008).

Appendix D

The Correctional Services of Canada 2007 Performance Report (p.13) the changes and challenges presented by this population between 1997 and 2005 within federal institutions:

- An increasing rate of infectious diseases - inmates now have a 7 to 10 times higher rate of HIV than the general Canadian population, and approximately a 30 times higher rate of Hepatitis C.
- More extensive histories of involvement with the court system as approximately 9 out of 10 offenders have previous criminal convictions.
- More extensive histories of violence and violent offences, with far more assessed as violence-prone, hostile, impulsive and aggressive on admission.
- An increase of more than 100% in the proportion of offenders who are classified as maximum security on admission - 13% are now classified at this level on admission.
- An increase of 14% in the proportion of offenders serving sentences for homicide which is more than one in four male offenders.
- An increase of 33% in the proportion of offenders with gang and/or organized crime affiliations - one in six men and one in ten women offenders, now have known affiliations.

The *Correctional Services of Canada 2007 Performance Report* (p.13) provides a glimpse of how the mental health needs of offenders changed between 1997 and 2005 within federal institutions:

- There were increased numbers in the mental health needs of offenders admitted into the federal system.
- Offenders were entering with an increased number of prior mental health diagnoses and problems such as addictions.
- An increase of 71% in the percentage of male offenders and 100% increase in women offenders identified at admission as having very serious mental health problems - 12% of male and 25% of women offenders.
- An increasing prevalence of learning disabilities as well as offenders with low functioning capacities.

- An increasing prevalence of substance abuse - approximately 4 out of 5 offenders who arrived at a federal institution with a serious substance abuse problem, with 1 out of 2 having committed their crime under the influence of drugs, alcohol or other intoxicants.
- The rate of offenders with identified mental health disorders whose parole had been revoked, while under CSC supervision, with or without a new conviction or charge increased since 2002 - 2003 to 56.1%.
- Since 2004, there was a steady increase in the rate of return to custody which suggests that offenders may have more serious and longer-term mental health problems and/or that the community's capacity for support of mental health cases has been eroding.

Appendix E

The economic burden for mental illness in Canada in 1998 by cost component was:

- $4.68 billion for direct costs or medical expenses and $3.19 billion for indirect costs or the value of time lost from work (Moore & Dejardins, 2002).
- Stephens & Joubert (2001) asserted that it is suspected to have been under-estimated, and that the total burden of mental health problems in 1998 was considered to be among the costliest conditions in Canada at $14.4 billion dollars.
- Health Canada reported in 2002 (Table 1-1) on the Burden of Adult mental health disorder prevalence in Canada 2001. Anxiety Disorders topped the mental health problems at 12.2 percent of one-year prevalence in populations 18 years and older.
- Waddell, Offord, Shepherd, Hua , & McEwan (2002) estimated the burden of child mental health disorder approximate prevalence in Canada during 2001 for (children aged 0 to 19) was: all anxiety disorders at 6.4 percent, attention deficit hyperactivity disorder at 4.8 percent, conduct disorder 4.2 percent and any depressive disorder at 3.5 percent.
- The incremental estimated economic burden of mental illnesses for persons aged 20 years and older in Canada in 2003 was about $51 billion dollars (Lim et al, 2008).

Appendix F

- Lost wages in Saskatchewan in 2003 due to mental illness as a percentage of Gross Provincial Product (GPP) was 0.36 % due to unemployment and 0.15% due to absenteeism (AMHB & IHE, p. 22).
- Substance abuse affects the well-being of future generations and translates into social costs through crime, injuries, and violence. Prescription, illicit, and social drugs are used by many to medicate away symptoms of mental health problems or cope with daily living then frequently appear together in people as concurrent disorders. The social costs of alcohol and illegal drugs (% of GPP) in Saskatchewan were identified by Rehm, Baliunas, & Brochu (2003) as 0.76 for drugs and 1.45 for illegal drugs.
- Workers who regularly take time away from work due to illness, cost companies and might seem less attractive to future employers. Twenty percent of all sick leave days from workers in Canada were due to mental illness compared to Austria at 4.2 percent (Curran, Knapp, McDaid, & Tómasson (2007).
- There was a significant difference in absenteeism days from work in Canada per year in 2003 of workers who live with mental health problems compared to workers who have none. For example: males (20–34 years) with no mental illness were absent 19.63 days compared to males with mental illness who were absent 54.56 days; males (35–49) with no mental illness were absent 27.13 days compared to males in the same age group with mental illness who were absent 73.65 days from work and older men (52–64 years) with no mental illness were absent from work 20.10 days compared to males with mental illness in the same age category who were absent 57.58 days from work (AMHB & IHE, 2007).
- Statistics for females employees showed greater differences for example: women (20-34 years) with no mental illness were absent from work 28.68 days compared to women of the same age who live with mental illness who were absent 79.01 days from work; females (35–49) with no mental illness missed work 20.76 days compared to females of the same age who were absent 72.62 days, the female workers aged (52–64) with no mental illness were away from work 30.6 days compared to women of the same age who had mental illness and were absent more than three months from work or 77.7 days (AMHB & IHE, 2007).

Appendix G

- Mental health problems are projected to be the 21st century population health challenge and predicted to be the leading cause of disability in Western nations by 2020 (CPA, 2007).
- The Global Business and Economic Round Table on Mental Health (2006) asserted the disability burden in Canada was remarkable.
- Economists are increasingly concerned that the forecasted rise in mental health problems has already begun to generate increased disability claims (CPA, 2007).
- Research shows mental illness is driving disability rates and overall health care costs within the North American labor force which is creating significant costs to business and impediments to productivity (Watson Wyatt, 2007).
- Public Health Reporter, André Picard (2008) described workers who live with mental illness as 'the working wounded' and claimed mental illness is costing the Canadian economy a staggering $51-billion a year for each day 500,000 people miss work because of psychiatric problems.
- For those in the population who live with mental health problems and secured employment tenure before symptom management or relapse became unmanageable could qualify for benefits, Canada Pension Plan disability payments have increased from $691 million in 2003 – 2004 to $795 million in 2005 – 2006 (AMHB & IHE, 2007, p.19).
- Great West Life reported that 30 percent of disability claims are related to mental illness. (Global Business and Economic Round Table on Mental Health & Addictions, 2006).
- The total direct private insurance claims in Canada in 2004 for all causes included short term income loss of $461 million and long term income loss of $2.2 billion. A total of 2,064 mental disorder claims were accepted by Workers' Compensation in Canada in 2004 (AMHB & IHE, 2007).

Appendix H

The Canadian Council on Learning (Feb. & April, 2009) estimates the cost of dropping out of school has staggering economic and social consequences for society. For example:

- Obtaining a high school education helps make people healthier (combined morbidity and mortality costs per high school drop-out is $8,000 yearly).
- 42.7 percent of all Canadian adult welfare recipients failed to complete a high school diploma (average yearly cost for these services is $4,000 per adult).
- Education or lack thereof, is thought to be the second-best predictor of risk for incarceration (average yearly cost of $200 per high school drop-out or approximately $350 million per year to the Canadian Justice system).
- There is strong evidence about the link between high school drop-outs and reduced potential to earn a reasonable living and greater risk to depend upon unemployment benefits (the cost to society is shocking due to the loss of income tax revenue, employment insurance premiums combined with the cost of employment insurance payments totals an estimated $3,000 per year per high school drop-out) (CCL, Feb. 2009).

Grim Truths

- Mental health conditions affect people of all ages, education, income levels, and cultures. Some groups may be more vulnerable such as the poor, women, the elderly, and indigenous populations (Bland, Orn, & Newman, 1998).
- The mental health conditions reported among individuals with developmental disorders are very similar to those found in the general population (Horwitz et al, 2000).
- 6 of the 10 leading causes of disability are mental disorders (CPA, 2007).
- Marked socioeconomic disparities were found in the use of care from a psychiatrist. Universal health care is insufficient to fairly distribute services to those most in need (Steele et al, 2006).
- 80% of all psychiatric disorders emerge in adolescence, and are the single most common illness with onset in the adolescent age group; yet, only 1 in 5 Canadian children who need mental health services currently receives them (Leitch,2007, Sun Life, 2006).
- Mental health problems among children and youth are predicted to increase by 50% by the year 2020 (Leitch, 2007).
- People with severe mental illness die 25 years earlier than the general population and a diagnosis of schizophrenia has been shown to reduce a patient's average life expectancy by 10 years (Torgovnick, 2008; Martin, 2009).
- Obesity-related illnesses (diabetes) are so prevalent among the mentally ill, that health officials call them an epidemic within an epidemic (Torgovnick, 2008).
- Alcohol misuse, including binge drinking, is commonly a precursor to and a risk factor for deliberate self-harm and suicide (Boyce, 2004; Canadian Centre on Substance Abuse, 2005).
- Suicide is a leading cause of death among Canadian adolescents and a public health concern for the suicide rates among Aboriginal youth is 2 to 6 times that of the overall Canadian population (Canadian Institute of Child Health, 2002; Stats Canada, 2005; Leitch, 2007).
- Senior victims of family violence were most likely to report being victimized by an adult child, current or former spouse (Stats Canada, 2008).

Fast Saskatchewan Facts

- In 2003/2004 the province spent only 3.5% of their health care expenditures on mental health (Jacobs et al, 2008).
- Medical Services Branch reported in 2007 – 2008 that there were a total of 40 psychiatrists who practice in Saskatchewan, 10 of these psychiatrists were aged 65 years or older.
- The province has a large seniors' population: 14.6 per cent of Saskatchewan residents were 65 or older in 2001, compared to 12.6 per cent of Canadians (HSURC, 2002).
- Our Aboriginal population is large at 11.4% of our overall population, versus 2.8% across Canada (HSURC, 2002).
- Saskatchewan has a higher than the national average teen pregnancy and infant mortality rates (Children's Advocate, 2008).
- Mental illness is the most common condition seen by health professionals at the University of Saskatchewan's Student Health Centre (Health Quality Council, 2004).
- Alcohol abuse in Saskatchewan is noted to be the highest in the country at 8.5 % (Health Canada, 1999, Addley, 2005).
- The probability an individual will develop an alcohol addiction problem in this province is greatest in one of the large urban centers and Northern Saskatchewan (Stats Canada, 2002; Stats Canada, 2003; CCSA, 2005).
- Everyone waits for service - in 2008 Regina Police Service members spent over 5,000 police hours in the ER awaiting psychiatric assessment of citizens in custody (Rabyj & Kemp, 2009).
- Low-income neighborhoods are associated with increased health care use in Saskatoon (Lemstra, Neudorf & Opondo, 2006).
- One in four women in Saskatchewan has experienced violence at the hands of a current or former spouse (Stats Canada, 2008).
- In 2000, there were 3,500 residents in shelters in Saskatchewan; 41% were women and 59% were dependent children; 96% of women residing in shelters were victims of abuse and a high percentage of women who use shelters are of Aboriginal ancestry (Stats Canada, 2006).

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